Form **5500**

Department of the Treasury Internal Revenue Service Department of Labor Pension and Welfare Benefits

Administration
Pension Benefit
Guaranty Corporation

Annual Return/Report of Employee Benefit Plan

This form is required to be filed under sections 104 and 4065 of the Employee Retirement Income Security Act of 1974 (ERISA) and sections 6047(e), 6057(b), and 6058(a) of the Internal Revenue Code (the Code).

► Complete all entries in accordance with the instructions to the Form 5500.

Official Use Only

OMB Nos. 1210-0110 / 1210-0089

2002

This Form is Open to Public Inspection.

Part Annual Repo	ort identif	ication int	ormation	n						
For the calendar plan ye or fiscal plan year begin		01	01	2002	and	i ending	12	31	20	02
A This return/report is for:	(1)	a multiemp	loyer plan;		(3)	a multipl	e-employeı	plan; or		
	(2)	a single-en a multiple-e		n (other than lan);	(4)	a DFE (specify)	······································		
B This return/report is:	(1)	the first ret	urn/report f	iled for the plan;	(3)	the final	return/repo	ort filed for th	e plan;	
	(2)	an amende	ed return/re	port;	(4)			eturn/report		
C If the plan is a collectively	/-bargained	olan, check h	ere		********		n 12 monti			
INEEL PLAN	BUS	SINE	SS	TRAV	EL	INS	URI	7 N C 1	<u>:</u> -	
1b Three-digit plan number	er (PN) ▶	501		1c E	fective date	of plan	04	01	196	6
Caution: A penalty for the la	ate or incon	nplete filing d	of this retu	rn/report will be	assessed	uniess reas	onable cau	ıse is estab	lished.	
Under penalties of perjury schedules, statements and at knowledge and belief, it is tru Signature of plan administra	and other petachments, and correct and the cor	enalties set for as well as the and complete.	orth in the in e electronic	nstructions, I decl version of this i	are that I ha eturn/repor	ave examine	d this return	a/report incl	udina accomn	anying t of my
SIGN HERE	anda	en F	Wilk	(unson)		Date	07	29	200	3
Type or print name of indi	vidual signing	as plan admin	istrator							
a CANDAC	E F	= WI	LKI	NSON	İ					
Signature of employer/plan	sponsor/DF	E	•							
SIGN HERE DO CANDA C	vidual signing	as employer, p	lan sponsor	or DFE		Date	07	29	200	3
For Paperwork Reduction A	ct Notice an	d OMB Cont	rol Numbe	ere eas the inetr	uctions for	· Form 5500	Cat N	lo 13500F	Form 5500	(2002)

Plan sponsor's name and address (employer, if for single-employer plan) (Address should include room or suite no.) 2a

BECHTEL BWXT IDAHO, LLC 1)

- c / o2)
- PO BOX: 1625 1955 FREEMONT AVE
- IDAHO FALLS

2b Employer Identification Number (EIN)

ID 83415-3200

94 3323797

2c Sponsor's telephone

208 526 0066

2d Business code (see instructions) 541990

8)

6)

7)

9)

- 3a Plan administrator's name and address (If same as plan sponsor, enter "Same")
- SAME 1)
- 2)

3)

4)

3b Administrator's EIN

5)

6)

3c Administrator's telephone number

7)

- If the name and/or EIN of the plan sponsor has changed since the last return/report filed for this plan, enter the name, EIN and the plan number from the last return/report below:
- Sponsor's name
- EIN

c PN

Form	5500	/2002

Official Use Only

5				,
а	a Name (including intri hame, ii applicable) and address			
1)	ı)			
	•	·		
2)				
3)	3)	b	EIN	
•		•		•
4)			•	
5)	5)	c	Telephone number	
	\\\\\\\\\\\\\.			
6)	5)			
				5100
6	Total number of participants at the beginning of the plan year	•••••	••••••	5189
7	7 Number of participants as of the end of the plan year (welfare plans complete only lines 7a, 7	7b, 7c	c, and 7d)	
a	a Active participants			5221
	a route partoparto	••••••	••••••	,
b	b Retired or separated participants receiving benefits		******	
C	c Other retired or separated participants entitled to future benefits		*************	
				~ ~ ~
d	d Subtotal. Add lines 7a, 7b, and 7c		************	522
8	e Deceased participants whose beneficiaries are receiving or are entitled to receive benefits			
	•			
f	f Total. Add lines 7d and 7e	•••••	*************	5221
				-
g	g Number of participants with account balances as of the end of the plan year (only defined contribution plans complete this item)			



h Number of participants that terminated employment during the plan year with accrued benefits that

I If any participant(s) separated from service with a deferred vested benefit, enter the number of

were less than 100% vested.....

separated participants required to be reported on a Schedule SSA (Form 5500)

- 8 Benefits provided under the plan (complete 8a and 8b, as applicable)
- a Pension benefits (check this box if the plan provides pension benefits and enter below the applicable pension feature codes from the List of Plan Characteristics Codes printed in the instructions):
- b Welfare benefits (check this box if the plan provides welfare benefits and enter below the applicable welfare feature codes from the List of Plan Characteristics Codes printed in the instructions):

40

9a Plan funding arrangement (check all that apply)

(1) X Insurance

(2) Code section 412(i) insurance contracts

(3) Trust

(4) General assets of the sponsor

9b Plan benefit arrangement (check all that apply)

(1) X

Insurance

- (n) O-d- ------- 440(i) i---
- (2) Code section 412(i) insurance contracts
- (3) Trust
- (4) General assets of the sponsor
- 10 Schedules attached (Check all applicable boxes and, where indicated, enter the number attached. See instructions.)
 - a Pension Benefit Schedules
- R (Retirement Plan Information)

2)

1)

T (Qualified Pension Plan Coverage Information)

If a Schedule T is not attached because the plan is relying on coverage testing information for a prior year, enter the year

3)

B (Actuarial Information)

4)

E (ESOP Annual Information)

5)

SSA (Separated Vested Participant Information)

- b Financial Schedules
- 1)
- 2)

3)

- 2)
- 001
- \mathcal{L}
- 4)
- 5)
- 6)
- 7)

- H (Financial Information)
- (Financial Information--Small Plan)
- A (Insurance Information)
- (Service Provider Information)
- D (DFE/Participating Plan Information)
- G (Financial Transaction Schedules)
- P (Trust Fiduciary Information)



SCHEDULE A (Form 5500)

Department of the Treasury Internal Revenue Service Department of Labor Pension and Welfare Benefits Administration

Pension Benefit Guaranty Corporation

Insurance Information

This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974.

File as an attachment to Form 5500.

Insurance companies are required to provide this information pursuant to ERISA section 103(a)(2).

Official Use Only

OMB No. 1210-0110

This Form is Open to Public Inspection.

For calendar plan year 2002 or fiscal plan year beginning.

01 2002

and ending

2002

A Name of plan

INEEL Business Travel Insurance Plan

Three-digit

plan number

50 I

C Plan sponsor's name as shown on line 2a of Form 5500

Bechtel BUXT Idaho, LLC

Employer Identification Number

3323797

Information Concerning Insurance Contract Coverage, Fees, and Commissions Part I

Provide information for each contract on a separate Schedule A. Individual contracts grouped as a unit in Parts II and III can be reported on a single Schedule A.

- 1 Coverage:
- (a) Name of insurance carrier

TRANSAMERICA DCCIDENTAL LIFE INSURANCE

95 1060502 (b) EIN

(c) NAIC code

67721

Contract or identification number

05228081

Approximate number of persons covered at end of policy or contract year

5221

Policy or contract year

(f) From

01 01 2002

31

2002

Insurance fees and commissions paid to agents, brokers and other persons. Enter the total fees and total commissions below and list agents, brokers and other persons individually in descending order of the amount paid in the items on the following page(s) in Part I.

Totals

Total amount of commissions paid

Total fees paid / amount

For Paperwork Reduction Act Notice and OMB Control Numbers, see the instructions for Form 5500. Cat. No. 135051 Schedule A (Form 5500) 2002

- (a) Name and address of the agents, brokers or other persons to whom commissions or fees were paid
- (b) Amount of commissions paid

(c) Fees paid / Amount

(e) Organization code

- (d) Fees paid / Purpose
- (a) Name and address of the agents, brokers or other persons to whom commissions or fees were paid
- (b) Amount of commissions paid

(c) Fees paid / Amount

(e) Organization code

- (d) Fees paid / Purpose
- (a) Name and address of the agents, brokers or other persons to whom commissions or fees were paid
- (b) Amount of commissions paid

(c) Fees paid / Amount

(e) Organization code

(d) Fees paid / Purpose



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Schedule	Α	(Form	5500)	2002

Official Use Only

Part II

Investment and Annuity Contract Information

Where individual contracts are provided, the entire group of such individual contracts with each carrier may be treated as a unit for purposes of this report.

- 3 Current value of plan's interest under this contract in the general account at year end
- 4 Current value of plan's interest under this contract in separate accounts at year end
- 5 Contracts With Allocated Funds
- a State the basis of premium rates
- b Premiums paid to carrier
- c Premiums due but unpaid at the end of the year
- e Type of contract
- (1)

individual policies

(2)

group deferred annuity

- (3) other (specify below)
- f If contract purchased, in whole or in part, to distribute benefits from a terminating plan check here

0-1-1-1-		15	EE00\	0000
Schedule	Α	(Form	55001	2002

Official Use Only

6 a	Contracts With Unallocated Funds (Do not include portions of these contracts maintained in separate accounts) a Type of contract									
	(1)	deposit administration	(2)	immediate participation guarantee		(3)	guaranteed investment			
	(4)	other (specify below)		•						
>		:								
b	Bala	nce at the end of the previous yea	ar	,	e E					
C	(1)	tlons: Contributions deposited during th	e year	· ,						
	(2)	Dividends and credits								
	(3)	Interest credited during the year	••••••				·			
	(4)	Transferred from separate accoun	nt							
	(5)	Other (specify below)								
•										
	(6)	Total additions								
		I of balance and additions (add buctions:	and c (6))							
	(1)	Disbursed from fund to pay bene purchase annuities during year								
	(2)	Administration charge made by o	arrier	•		,	e see			
	(3)	Transferred to separate account	***************************************							
	(4)	Other (specify below)	***************************************							
>										
	(5)	Total deductions								
1	Bala	ance at the end of the current yea	r (subtract e	(5) from d)						



Schedule .	A (Form	5500)	2002
CONSTRUCT A	\sim 1	(1 01111	2200	2002

Official Use Only

Part III Welfare Benefit Contract Information

If more than one contract covers the same group of employees of the same employer(s) or members of the same employee organization(s), the information may be combined for reporting purposes if such contracts are experience-rated as a unit. Where individual contracts are provided, the entire group of such individual contracts with each carrier may be treated as a unit for purposes of this report.

7 Benefit and contract type (check all applicable boxes)

(a)		Health (other than dental or vision)	(b)	Dental	(c)		Vision [®]	(d)	Life Insurance
(e)		Temporary disability (accident and sickness)	(f)	Long-term disability	(g)	ŗ	Supplemental unemployment	(h)	Prescription drug
(i)		Stop loss (large deductible)	()	HMO contract	(k)		PPO contract	(1)	Indemnity contract
	V								

(m) X Other (specify below)

► TRAVEL ACCIDENTAL DEATH & DISMEMBER

8 Experience-rated contracts

ì	Prer	niums:
	(1)	Amount received
	(2)	Increase (decrease) in amount due but unpaid
	(3)	Increase (decrease) in unearned premium reserve
	(4)	Earned ((1) + (2) - (3))
	Ben	efit charges:
	(1)	Claims paid
	(2)	Increase (decrease) in claim reserves
	(3)	Incurred claims (add (1) and (2))
	(4)	Claims charged

U	HOI	namuer of premium.	•
	(1)	Retention charges (on an accrual basis)	
		(A) Commissions	
		(B) Administrative service or other fees	
		(C) Other specific acquisition costs	•
		(D) Other expenses	
		(E) Taxes	
		(F) Charges for risks or other contingencies	
		(G) Other retention charges	
		(H) Total retention	
	(2)	Dividends or retroactive rate refunds.	
		(These amounts were 1) paid in cash, or 2) credited.)	
d		tus of policyholder reserves at end of year: Amount held to provide benefits after retirement	
	(2)	Claim reserves	
	(2)		
	(3)	Other reserves	
е		ridends or retroactive rate refunds due. o not include amount entered in c <i>(2).</i>)	
9	Nor	nexperience-rated contracts:	
		·	3300
а	Tota	al premiums or subscription charges paid to carrier	
b	in c	he carrier, service, or other organization incurred any specific costs connection with the acquisition or retention of the contract or policy, ser than reported in Part I, item 2 above, report amountecify nature of costs below	

Form **5500**

Department of the Treasury Internal Revenue Service Department of Labor Pension and Welfare Benefits Administration

Pension Benefit

Guaranty Corporation

Annual Return/Report of Employee Benefit Plan

This form is required to be filed under sections 104 and 4065 of the Employee Retirement Income Security Act of 1974 (ERISA) and sections 6047(e), 6057(b), and 6058(a) of the Internal Revenue Code (the Code).

► Complete all entries in accordance with the instructions to the Form 5500.

Official Use Only

OMB Nos. 1210-0110 / 1210-0089

2002

This Form is Open to Public Inspection.

Part I Annual Repo	ort Identifi	cation Information	n						
For the calendar plan ye or fiscal plan year begin		01 01	2002	and e	ending	12	31	20	002
A This return/report is for:	(1)	a multiemployer plan;		(3) r	a multiple	e-employe	r plan; or		
	(2)	a single-employer plat a multiple-employer p		(4)	a DFE (s	pecify)	•••••••••••••••••••••••••••••••••••••••		
B This return/report is:	(1)	the first return/report	filed for the plan;	(3)	the final	return/rep	ort filed for th	e plan;	
C If the plan is a collectively	(2)	an amended return/re	•	(4)	(less that	n 12 mont	•		
D If filing under an extension	n of time or t	he DFVC program, che	ck box and attach	required info	rmation. (s	ee instruc	tions)	>	
		n enter all reque		-					
TNEEL	FLF	XIBLE	BENE	FIT	5 F	LA	V		
	,	ATOCE	02.00	, , ,			-		
1b Three-digit plan number	er (PN) ▶	506	1c Eff	ective date o	of plan	01	01	19	89
Caution: A penalty for the I		-	•						
Under penaities of perjury schedules, statements and at knowledge and belief, it is tru Signature of plan administra	ltachments, a le, correct ar	is well as the electronic	nstructions, I declar c version of this re	re that I have turn/report if	e examined f it is being	d this retur g filed ele	n/report, incl ctronically, ar	uding acco	ompanying best of my
		ce b. Wilke	nsow		Date	07	29	20	03
Type or print name of indi	ividual signing	as plan administrator							
a CANDAC	LE F	WILK	INSON						
Signature of employer/plan									
SIGN HERE	andoc	e S. The	!kinson)	Date	07	29	20	03
•••••		as employer, plan sponsor							
b CANDAC	EP	WILKI	NSON						
For Paperwork Reduction A	ct Notice an	d OMB Control Numb	ers, see the instru	ctions for F	orm 5500.	. Cat.	No. 13500F	Form 5 5	5 00 (2002)

Official Use Only

2a Plan sponsor's name and address (employer, if for single-employer plan) (Address should include room or suite no.)

1) BECHTEL BWXT IDAHO, LLC

2) C / O

6)

7)

8)

9)

3a

5)

7)

- 3) PO BOX: 1625 1955 FREEMONT AVE
- 4) IDAHO FALLS

2b Employer Identification Number (EIN)

5) ID 83415-3200

94 3323797

2c Sponsor's telephone

208 526 0066

2d Business code (see instructions) 541990

Plan administrator's name and address (If same as plan sponsor, enter "Same")

- 1) SAME
- 2) C / O

3)

4) 3b Administrator's EIN

6) 3c Administrator's telephone number

- 4 If the name and/or EIN of the plan sponsor has changed since the last return/report filed for this plan, enter the name, EIN and the plan number from the last return/report below:
- a Sponsor's name

b EIN

c PN



Form	5500	(2002

Official Use Only

Prepar	erı	nio	rma	uon	(optional)	1

a Name (including firm name, if applicable) and address

2)

1)

3)

4)

5)

6)

EIN

Telephone number

6 Total number of participants at the beginning of the plan year

2118

Number of participants as of the end of the plan year (welfare plans complete only lines 7a, 7b, 7c, and 7d)

a Active participants

2069

b Retired or separated participants receiving benefits.....

c Other retired or separated participants entitled to future benefits.....

d Subtotal. Add lines 7a, 7b, and 7c

2069

e Deceased participants whose beneficiaries are receiving or are entitled to receive benefits.....

f Total. Add lines 7d and 7e

2069

g Number of participants with account balances as of the end of the plan year (only defined contribution plans complete this item)

h Number of participants that terminated employment during the plan year with accrued benefits that were less than 100% vested.....

I If any participant(s) separated from service with a deferred vested benefit, enter the number of separated participants required to be reported on a Schedule SSA (Form 5500)......

- Benefits provided under the plan (complete 8a and 8b, as applicable)
- a Pension benefits (check this box if the plan provides pension benefits and enter below the applicable pension feature codes from the List of Plan Characteristics Codes printed in the instructions):
- b X Welfare benefits (check this box if the plan provides welfare benefits and enter below the applicable welfare feature codes from the List of Plan Characteristics Codes printed in the instructions):

4 Q

- 9a Plan funding arrangement (check all that apply)
 - (1) Insurance
 - (2) Code section 412(i) insurance contracts

(3)

1)

4)

(4) X General assets of the sponsor

- 9b Plan benefit arrangement (check all that apply)
 - (1) insurance
 - (2) Code section 412(i) insurance contracts
 - (3) Trust
 - (4) K General assets of the sponsor
- 10 Schedules attached (Check all applicable boxes and, where indicated, enter the number attached. See instructions.)
 - a Pension Benefit Schedules

Trust

- R (Retirement Plan Information)
- T (Qualified Pension Plan Coverage Information)

If a Schedule T is not attached because the plan is relying on coverage testing information for a prior year, enter the year

- 3)
 - B (Actuarial Information)
 - E (ESOP Annual Information)
- 5) SSA (Separated Vested Participant Information)

- b Financial Schedules
 - 1)
- 2)
- 3)
- 4) X
- 5)
- 6)
- 7)

- H (Financial Information)
- (Financial Information--Small Plan)
- A (Insurance Information)
- C (Service Provider Information)
- D (DFE/Participating Plan Information)
- G (Financial Transaction Schedules)
- P (Trust Fiduciary Information)



SCHEDULE C (Form 5500)

Department of the Treasury Internal Revenue Service

Department of Labor Pension and Welfare Benefits Administration

Pension Benefit Guaranty Corporation

Service Provider Information

This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974.

File as an attachment to Form 5500.

Official Use Only
OMB No. 1210-0110

2002

This Form is Open to Public Inspection.

For calendar plan year 2002 or fiscal plan year beginning.

01 01

2002

and ending

12 3

Employer Identification Number

2002

A Name of plan

INEEL Flexible Benefits Plan

Three-digit plan number

506

C Plan sponsor's name as shown on line 2a of Form 5500

Bechtel BWXT Idaho, LLC

Part I Service Provider Information (see instructions)

- 1 Enter the total dollar amount of compensation paid by the plan to all persons, other than those listed below, who received compensation during the plan year:
- 2 On the first item below list the contract administrator, if any, as defined in the instructions. On the other items, list service providers in descending order of the compensation they received for the services rendered during the plan year. List only the top 40. 103-12 IEs should enter N/A in (c) and (d).
 - (a) Name

AETNA US HEALTHCARE

(b) Employer identification number (see instructions)

octions) 06 6033 492

(c) Official plan position

 (d) Relationship to employer, employee organization, or person known to be a party-in-interest

CLAIMS PROCESSING

94942

Contract administrator

(e) Gross salary or allowances paid by plan

(f) Fees and commissions paid by plan

(g) Nature of service code(s)

(see instructions) 1 2

- (a) Name
- (b) Employer identification number (see instructions)
- (c) Official plan position
- (d) Relationship to employer, employee organization, or person known to be a party-in-interest
- (e) Gross salary or allowances paid by plan
- (f) Fees and commissions paid by plan
- (g) Nature of service code(s) (see instructions)

For Paperwork Reduction Act Notice and OMB Control Numbers, see the instructions for Form 5500. Cat. No. 13515E Schedule C (Form 5500) 2002



- (a) Name
- (b) Employer identification number (see instructions)
- (c) Official plan position
- (d) Relationship to employer, employee organization, or person known to be a party-in-interest
- (e) Gross salary or allowances paid by plan
- (f) Fees and commissions paid by plan
- (g) Nature of service code(s) (see

instructions)

- (a) Name
- (b) Employer identification number (see instructions)
- (c) Official plan position
- (d) Relationship to employer, employee organization, or person known to be a party-in-interest
- (e) Gross salary or allowances paid by plan
- (f) Fees and commissions paid by plan
- (g) Nature of service code(s) (see

instructions)

- (a) Name
- (b) Employer identification number (see instructions)
- (c) Official plan position
- (d) Relationship to employer, employee organization, or person known to be a party-in-interest
- (e) Gross salary or allowances paid by plan
- (f) Fees and commissions paid by plan
- (g) Nature of service code(s) (see

instructions)

- (a) Name
- (b) Employer identification number (see instructions)
- (c) Official plan position
- (d) Relationship to employer, employee organization, or person known to be a party-in-interest
- (e) Gross salary or allowances paid by plan
- (f) Fees and commissions paid by plan
- (g) Nature of service code(s) (see instructions)



Schedule C (Form 5500) 2002 Part II Termination Information on Accountants and Enrolled Actuaries (see Instructions) (a) Name (b) EIN (c) Position (d) Address (e) Telephone No. EXPLANATION (a) Name (c) Position (b) EIN (d) Address (e) Telephone No. EXPLANATION

Official Use Only



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=orm 5500

Department of the Treasury
Internal Revenue Service
Department of Labor
Pension and Welfare Benefits
Administration
Pension Benefit

Annual Return/Report of Employee Benefit Plan

This form is required to be filed under sections 104 and 4065 of the Employee Retirement Income Security Act of 1974 (ERISA) and sections 6047(e), 6057(b), and 6058(a) of the Internal Revenue Code (the Code).

► Complete all entries in accordance with the instructions to the Form 5500.

Official Use Only

OMB Nos. 1210-0110 / 1210-0089

2002

This Form is Open to Public Inspection.

Part I Annual Repo	ort iden	tification Info	rmatio	n					•
For the calendar plan ye or fiscal plan year begin		01	01	200	and	ending	12	31	2002
A This return/report is for:	(1)	a multiemplo	yer plan;		(3)	a multip	ole-employer	plan; or	
	(2)	a single-emp a multiple-en		n (other than lan);	(4)	a DFE	(specify)	••••••	
B This return/report is:	(1)	the first retu	n/report	filed for the p	lan; (3)	the fina	l return/repo	rt filed for th	e plan;
*	(2)	an amended	return/re	eport;	(4)		plan year re an 12 month	•	
C If the plan is a collectively	y-bargaine	ed plan, check hei	·············			••••••		••••••	
Part II Basic Plan I 1a Name of plan INEE L		sion enter al) -	-		
1b Three-digit plan numb	er (PN) ▶	509		10	: Effective date	of plan	01	01	1993
Caution: A penalty for the	late or inc	complete filing of	f this retu	urn/report wii	l be assessed	unless rea	sonable cau	ıse is estab	lished.
Under penalties of perjury schedules, statements and a knowledge and belief, it is tr Signature of plan administr	ittachment ue, correc	ts, as well as the	th in the i electroni	instructions, I Ic version of I	declare that I hat this return/repor	ave examine t if it is bei	ed this return ng filed elec	n/report, incl tronically, a	uding accompanying nd to the best of my
		ace The	lkis	rson		Date	07	29	2003
Type or print name of inc	-	- '			•				
· CANDA	CE	F WI	LKI	1 NS 0	N				
Signature of employer/plan	sponsor/	DFE							
SIGN HERE DA A Type or print name of inc	dividual sign	ning as employer, pla	an sponso	r or DFE		Date	67	29	2003
For Paperwork Reduction A						r Form 550	0. Cat. N	lo. 13500F	Form 5500 (2002

Official Use Only

2a	Plan sponsor's name	and address (employer,	if for single-employer pla	an) (Address should include i	oom or suite no.)
----	---------------------	------------------------	----------------------------	-------------------------------	-------------------

BECHTEL BWXT IDAHO, LLC

c / o 2)

PO BOX: 1625 1955 FREEMONT AVE

IDAHO FALLS

2b Employer Identification Number (EIN)

ID 83415-3200

94 3323797 208 526 0066

2c Sponsor's telephone

2d Business code (see instructions) 541996

8) 9)

6)

7)

3a Plan administrator's name and address (If same as plan sponsor, enter "Same")

SAME 1)

c/o2)

3)

4)

3b Administrator's EIN

5)

6) 3c Administrator's telephone number

7)

If the name and/or EIN of the plan sponsor has changed since the last return/report filed for this plan, enter the name, EIN and the plan number from the last return/report below:

Sponsor's name

EIN

c PN



1417

5	Preparer	information	(optional)	
---	----------	-------------	------------	--

a Name (including firm name, if applicable) and address

2)

1)

3)

4)

5)

6)

Telephone number

EIN

7 Number of participants as of the end of the plan year (welfare plans complete only lines 7a, 7b, 7c, and 7d)

c Other retired or separated participants entitled to future benefits.....

e Deceased participants whose beneficiaries are receiving or are entitled to receive benefits.....

1 Total. Add lines 7d and 7e

g Number of participants with account balances as of the end of the plan year (only defined contribution plans complete this item)

h Number of participants that terminated employment during the plan year with accrued benefits that were less than 100% vested......

I If any participant(s) separated from service with a deferred vested benefit, enter the number of separated participants required to be reported on a Schedule SSA (Form 5500)

3 E	Benefits pro	vided under	the	plan	(complete	8a	and 8b.	as	applicable)
-----	--------------	-------------	-----	------	-----------	----	---------	----	-------------

- Pension benefits (check this box if the plan provides pension benefits and enter below the applicable pension feature codes from the List of Plan Characteristics Codes printed in the instructions):
- Welfare benefits (check this box if the plan provides welfare benefits and enter below the applicable welfare feature codes from the List of Plan Characteristics Codes printed in the instructions):

4E

- 9a Plan funding arrangement (check all that apply) 9b Plan benefit arrangement (check all that apply) (1) Insurance
 - (2)Code section 412(i) insurance contracts Code section 412(i) insurance contracts
 - (3) Trust (3) Trust
 - (4) General assets of the sponsor (4) General assets of the sponsor
- Schedules attached (Check all applicable boxes and, where indicated, enter the number attached. See instructions.)

a Pension Benefit Schedules

- 1) (Retirement Plan Information)
- 2) (Qualified Pension Plan Coverage Information)

If a Schedule T is not attached because the plan is relying on coverage testing information for a prior year, enter the year

- 3) (Actuarial Information)
- (ESOP Annual Information) 4)
- 5) SSA (Separated Vested Participant Information)

1) H (Financial Information)

Insurance

b Financial Schedules

4)

5)

6)

7)

- 2) (Financial Information--Small Plan)
 - 001 X (Insurance Information)
 - (Service Provider Information)
 - (DFE/Participating Plan Information)
 - G (Financial Transaction Schedules)
 - (Trust Fiduciary Information)



SCHEDULE A (Form 5500)

Department of the Treasury Internal Revenue Service Department of Labor Pension and Welfare Benefits

Administration Pension Benefit Guaranty Corporation

Insurance Information

This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974.

File as an attachment to Form 5500.

Insurance companies are required to provide this information pursuant to ERISA section 103(a)(2).

Official Use Only

OMB No. 1210-0110

This Form is Open to Public Inspection.

For calendar plan year 2002 or fiscal plan year beginning.

01 2001

and ending

12

2002

A Name of plan

INEEL VISION CARE PLAN

Three-digit plan number 509

Plan sponsor's name as shown on line 2a of Form 5500

BECHTEL BUXT IDAHO, LLC

D **Employer Identification Number**

3323797

Part I Information Concerning Insurance Contract Coverage, Fees, and Commissions

Provide information for each contract on a separate Schedule A. Individual contracts grouped as a unit in Parts II and III can be reported on a single Schedule A.

- Coverage:
- Name of insurance carrier

VISION SERVICE PLAN

- 82 0339119 (b) EIN
- (c) NAIC code
- 47783

- Contract or identification number
- 12154777
- (e) Approximate number of persons covered at end of policy or contract year

1400

Policy or contract year

- 01 01 2002

Insurance fees and commissions paid to agents, brokers and other persons. Enter the total fees and total commissions below and list agents, brokers and other persons individually in descending order of the amount paid in the items on the following page(s) in Part I.

Totals

Total amount of commissions paid

Total fees paid / amount

For Paperwork Reduction Act Notice and OMB Control Numbers, see the instructions for Form 5500. Cat. No. 13505I Schedule A (Form 5500) 2002

- (a) Name and address of the agents, brokers or other persons to whom commissions or fees were paid
- (b) Amount of commissions paid

(c) Fees paid / Amount

(e) Organization code

- (d) Fees paid / Purpose
- (a) Name and address of the agents, brokers or other persons to whom commissions or fees were paid
- (b) Amount of commissions paid

(c) Fees paid / Amount

(e) Organization code

- (d) Fees paid / Purpose
- (a) Name and address of the agents, brokers or other persons to whom commissions or fees were paid
- (b) Amount of commissions paid

(c) Fees paid / Amount

(e) Organization code

(d) Fees paid / Purpose



Schedule	Α	(Form	5500)	2002
00.104410	•	(1 01111		2002

Official Use Only

Part II

Investment and Annuity Contract Information

Where individual contracts are provided, the entire group of such individual contracts with each carrier may be treated as a unit for purposes of this report.

- 3 Current value of plan's interest under this contract in the general account at year end
- 4 Current value of plan's interest under this contract in separate accounts at year end
- 5 Contracts With Allocated Funds
- a State the basis of premium rates
- **b** Premiums paid to carrier
- c Premiums due but unpaid at the end of the year
- e Type of contract
- (1)

individual policies

(2)

group deferred annuity

- (3) other (specify below)
- f If contract purchased, in whole or in part, to distribute benefits from a terminating plan check here

Schedule	Α	(Form	55001	2002

Official Use Only

a		tracts With Unallocated Funds (Do no of contract	ot include p	portions of these contracts maintained in sep	arate accou	ints) .
	(1)	deposit administration	(2)	immediate participation guarantee	(3)	guaranteed investment
	(4)	other (specify below)		·		
>		:		ى		
b	Bala	nce at the end of the previous year .	•••••			
C		tions: Contributions deposited during the y	ear	. ,		
	(2)	Dividends and credits				
	(3)	Interest credited during the year	••••••			
	(4)	Transferred from separate account	••••••	-		
	(5)	Other (specify below)	••••••			
>						
	(6)	Total additions	•••••••••••••••••••••••••••••••••••••••			
		of balance and additions (add b and	d c <i>(6)</i>)			
	(1)	Disbursed from fund to pay benefits purchase annuities during year				
	(2)	Administration charge made by carri	er			
	(3)	Transferred to separate account			•	
	(4)	Other (specify below)	••••••			
>						
	(5)	Total deductions				
f	Bala	nce at the end of the current year (s	ubtract e(5	5) from d)		



Schedule	Α	(Form	5500	2002
001104410	• •	(. 0	0000	,

Official Use Only

Part III

Welfare Benefit Contract Information

If more than one contract covers the same group of employees of the same employer(s) or members of the same employee organization(s), the information may be combined for reporting purposes if such contracts are experience-rated as a unit. Where individual contracts are provided, the entire group of such individual contracts with each carrier may be treated as a unit for purposes of this report.

7 Benefit and contract type (check all applicable boxes)

(a)	Health (other than dental or vision)	(b)	Dental	(c)	X	Vision	(d)	Life Insurance
(e)	Temporary disability (accident and sickness)	(f)	Long-term disability	(g)	j.	Supplemental unemployment	(h)	Prescription drug
(1)	Stop loss (large deductible)	(I)	HMO contract	(k)		PPO contract	(I)	Indemnity contract
(m)	Other (specify below)		· .					

8	Fxn	aria	nna	_rate	d c	nntr	acto

b

	·
Prei	miums:
(1)	Amount received
(2)	Increase (decrease) in amount due but unpaid
(3)	Increase (decrease) in unearned premium reserve
(4)	Earned ((1) + (2) - (3))
Ben	efit charges:
(1)	Claims paid
(2)	Increase (decrease) in claim reserves
(3)	Incurred claims (add (1) and (2))
(4)	Claims charged

C	Rem	ainder of premium:				
	(1)	Retention charges (on an accrual bas				
		(A) Commissions	······································			
		(B) Administrative service or other fe	es			
		(C) Other specific acquisition costs				
		(D) Other expenses				
		(E) Taxes	*************	;	v r	
		(F) Charges for risks or other conting	gencies			
		(G) Other retention charges				
		(H) Total retention	•••••••••••	••••••		
	(2)	Dividends or retroactive rate refunds.	•			
		(These amounts were 1) pa	aid in cash, or 2)	credited.)		
d	Stat	s of policyholder reserves at end of ye	aar:			
		Amount held to provide benefits after		••••••		
	(2)	Claim reserves		•••••		
					**American v.	
	(3)	Other reserves		••••••		
	Divi	ends or retroactive rate refunds due.				
9		not include amount entered in c(2).)		•••••		
9	Non	xperience-rated contracts:				
а	Tota	premiums or subscription charges pai	d to carrier	••••••		<i>305</i> 311
h	If the	carrier, service, or other organization	incurred any specific costs	3		
-	in co	nnection with the acquisition or retenti	on of the contract or policy	<i>'</i> ,		
		than reported in Part I, item 2 above, ify nature of costs below	report amount	•••••		

Form **5500**

Department of the Treasury
Internal Revenue Service
Department of Labor
Pension and Weifare Benefits
Administration
Pension Benefit

Guaranty Corporation

Annual Return/Report of Employee Benefit Plan

This form is required to be filed under sections 104 and 4065 of the Employee Retirement Income Security Act of 1974 (ERISA) and sections 6047(e), 6057(b), and 6058(a) of the Internal Revenue Code (the Code).

► Complete all entries in accordance with the instructions to the Form 5500.

Official Use Only

OMB Nos. 1210-0110 / 1210-0089

2002

This Form is Open to Public Inspection.

Annual Repo			cation inf	ormation	1					
For the calendar plan ye or fiscal plan year begin	ar 200 ning	2	10	01	2002	and	d ending	09	30	2003
A This return/report is for:	(1)		a multiemp	loyer plan;		(3)	a multip	le-employer	plan; or	•
	(2)	χ	a single-em a multiple-e		n (other than lan);	(4)	a DFE ((specify)		
B This return/report is:	(1)	:	the first ret	urn/report f	filed for the plan	(3)	the fina	l return/repo	rt filed for th	e plan;
	(2)		an amende	d return/re	port;	(4)		plan year re	•	
C If the plan is a collectively	y-bargai	ined p	lan, check he	ərə	•			an 12 month		>
Part II Basic Plan II 1a Name of plan	4.						normauon. (see instructi	ons)	··········
INEEL	DA	EN	TAL	- CH	ARE 1	CAN)			
							•			
			e e e e e e e e e e e e e e e e e e e	4						
1b Three-digit plan numb	er (PN)	>	510	•	1c	Effective dat	e of plan	01	01	1995
Caution: A penalty for the Under penalties of perjury schedules, statements and a knowledge and belief, it is to signature of plan administr SIGN HERE	and oth ttachme ue, corr ator	her pe ents, a ect ar	nalties set fo	orth in the li e electronic	nstructions, I de c version of this	clara that 1 h	ave examine rt if it is beli	od this matur	v/report, inclutronically, an	udina socomnomia
Type or print name of ind					asno		Date	0.4	<i>p</i> U	2007
· CANDAO	CF	F	= W1	LKI	NSOI	V		•		
Signature of employer/plan				***************************************				*	art en	rage problems and a
SIGN HERE	g g	all	S. 7.	elken	aon		Date	04	20	2004
Type or print name of ind	lividual s	igning	as employer, p	olan sponsor	or DFE				/	·
b CANDA	CE	F	= W1	LKI	NSON	7			. /	
For Paperwork Reduction A	ct Not	ice an	d OMB Con	trol Numb	ers, see the ins	tructions fo	r Form 550	0. Cat. N	io. 13500F	Form 5500 (2002
			Δ4		O V V	- A 4				

Plan sponsor's name and address (employer, if for single-employer plan) (Address should include room or suite no.)

BECHTEL BWXT FOAHO, LLC 1)

CIO CANDACE F WILKINSON

PO BOX 1625 1955 FREEMONT AVE

IDAHO FALLS

2b Employer Identification Number (EIN)

ID 83415-3200

94 3323797

2c Sponsor's telephone

208 526 0066

'2d Business code

Business code (see instructions) 541990

7) 8)

6)

9)

3a Plan administrator's name and address (If same as plan sponsor, enter "Same")

SAME 1)

2)

3)

4)

5)

3b Administrator's EIN

6)

7)

3c Administrator's telephone number

If the name and/or EIN of the plan sponsor has changed since the last return/report filed for this plan, enter the name, EIN and the plan number from the last return/report below:

Sponsor's name

b **EIN** c PN



4893

205

5 Preparer information (optional)

Name (including firm name, if applicable) and address

2)

1)

3)

4)

5)

61

b EIN

Telephone numbe

Total number of participants at the beginning of the plan year

Number of participants as of the end of the plan year (welfare plans complete only lines 7a, 7b, 7c, and 7d)

a Active participants

b Retired or separated participants receiving benefits.....

c Other retired or separated participants entitled to future benefits.....

d Subtotal. Add lines 7a, 7b, and 7c

f Total. Add lines 7d and 7e

e Deceased participants whose beneficiaries are receiving or are entitled to receive benefits

g Number of participants with account balances as of the end of the plan year (only defined contribution plans complete this item)

h Number of participants that terminated employment during the plan year with accrued benefits that were less than 100% vested

I If any participant(s) separated from service with a deferred vested benefit, enter the number of separated participants required to be reported on a Schedule SSA (Form 5500).....

Official Use Only

8	Benefits	provided	under the	ə plan	(complete	8a	and	8b. a	as ar	plicable	e)
---	----------	----------	-----------	--------	-----------	----	-----	-------	-------	----------	----

- Pension benefits (check this box if the plan provides pension benefits and enter below the applicable pension feature codes from the List of Plan Characteristics Codes printed in the instructions):
- (check this box if the plan provides welfare benefits and enter below the applicable welfare feature codes from the List Welfare benefits of Plan Characteristics Codes printed in the instructions):

HD

9a Plan funding arrangement (check all that apply) 9b Plan benefit arrangement (check all that apply) Insurance Insurance (2)Code section 412(i) insurance contracts (2)Code section 412(i) insurance contracts (3) Trust (3)Trust

Schedules attached (Check all applicable boxes and, where indicated, enter the number attached. See instructions.)

(Qualified Pension Plan

a Pension Benefit Schedules

(4)

- 1) R (Retirement Plan Information) 2)
 - Coverage Information) If a Schedule T is not attached

General assets of the sponsor

because the plan is relying on coverage testing information for a prior year, enter the year

- (Actuarial Information) (ESOP Annual Information)
- 5) SSA (Separated Vested Participant Information)

b Financial Schedules

(4)

H (Financial Information)

General assets of the sponsor

- 2) (Financial Information--Small Plan)
- 002 (Insurance Information)
 - (Service Provider Information)
- 5) (DFE/Participating Plan Information)
 - G (Financial Transaction Schedules)
 - P (Trust Fiduciary Information)



SCHEDULE A (Form 5500)

Department of the Treasury Internal Revenue Service

Department of Labor Pension and Welfare Benefits Administration

Pension Benefit Guaranty Corporation

For calendar plan year 2002 or fiscal plan year beginning

Insurance Information

This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974.

File as an attachment to Form 5500.

▶ Insurance companies are required to provide this information pursuant to ERISA section 103(a)(2).

Official Use Only

OMB No. 1210-0110

This Form is Open to Public Inspection.

A Name of plan

INEEL DENTAL CARE PLAN

and ending

09

2003

01 2002

В

Three-digit plan number

510

Plan sponsor's name as shown on line 2a of Form 5500

Employer Identification Number

3323797

BECHTEL BUXT IDAHO, LLC

Information Concerning Insurance Contract Coverage, Fees, and Commissions

Provide information for each contract on a separate Schedule A. Individual contracts grouped as a unit in Parts II and III

- 1 Coverage:
- (a) Name of insurance carrier

DELTA DENTAL PLAN OF CALIFORNIA

(b) EIN

94 1461312

(c) NAIC code

(d) Contract or identification number

5440

(e) Approximate number of persons covered at end of policy or contract year

4980

Policy or contract year

01 01 2002

2002

insurance fees and commissions paid to agents, brokers and other persons. Enter the total fees and total commissions below and list agents, brokers and other persons individually in descending order of the amount paid in the items on **Totals**

Total amount of commissions paid

Total fees paid / amount

For Paperwork Reduction Act Notice and OMB Control Numbers, see the instructions for Form 5500. Cat. No. 13505i Schedule A (Form 5500) 2002



(a) Name and address of the agents, brokers or other persons to whom commissions or fees were paid

(b) Amount of commissions paid

(c) Fees paid / Amount

(e) Organization code

(d) Fees paid / Purpose

(a) Name and address of the agents, brokers or other persons to whom commissions or fees were paid

(b) Amount of commissions paid

(c) Fees paid / Amount

(e) Organization code

(d) Fees paid / Purpose

(a) Name and address of the agents, brokers or other persons to whom commissions or fees were paid

(b) Amount of commissions paid

(c) Fees paid / Amount

(e) Organization code

(d) Fees paid / Purpose



Schedule	Α	(Form	5500	2002
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Official Use Only

Part	
------	--

Investment and Annuity Contract Information

Where individual contracts are provided, the entire group of such individual contracts with each carrier may be treated as a unit for purposes of this report.

- Current value of plan's interest under this contract in the general account at year end
- Current value of plan's interest under this contract in separate accounts at year end
- Contracts With Allocated Funds
- a State the basis of premium rates
- b Premiums paid to carrier
- c Premiums due but unpaid at the end of the year
- d If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, enter amount Specify nature of costs

- Type of contract
- individual policies
- (2)

group deferred annuity

(3) other (specify below)

(1)

f If contract purchased, in whole or in part, to distribute benefits from a terminating plan check here

Official Use Only

(1)	deposit administration	(2)	immediate participation guarantee	(3)	guaranteed investment
(4)	other (specify below)				
Baland	e at the end of the previous year	r			
Additio	ons:				
(1) C	contributions deposited during the	e year	••••		
<i>(2)</i> C	Dividends and credits	••••••			
<i>(3)</i> li	nterest credited during the year .				
<i>(4)</i> T	ransferred from separate accour	t			
(5) (Other (specify below)		••••		
				4	
<i>(6)</i> 1	otal additions				
			,		
		and c <i>(6)</i>)			
	ctions: Disbursed from fund to pay bene	fite or			
	purchase annuities during year				
(2)	Administration charge made by o	arrier			
(3)	Fransferred to separate account.				
(4)	Other (specify below)				
			. The second of the second constant $\mathcal{A}^{(k)}$ is the second constant of the second constant of $\mathcal{A}^{(k)}$		
		, 18 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1			
<i>(5</i>)	Total deductions				



Part III

Welfare Benefit Contract Information

If more than one contract covers the same group of employees of the same employer(s) or members of the same employee organization(s), the information may be combined for reporting purposes if such contracts are experience-rated as a unit. Where individual contracts are provided, the entire group of such individual contracts with each carrier may be treated as a unit for purposes of this report.

7 Benefit and contract type (check all applicable boxes)

(a)	Health (other than dental or vision)	(b)	X	Dental	(c)	Vision	(d)	Life Insurance
(e)	Temporary disability (accident and sickness)	(f)		Long-term disability	(g)	Supplemental unemployment	(h)	Prescription drug
(I)	Stop loss (large deductible)	()		HMO contract	(k)	PPO contract	(I)	Indemnity contract
(m)	Other (specify below)				,			

8 Experience-rated contracts

a	Prer (1)	niums: Amount received	4336242
	(2)	Increase (decrease) in amount due but unpaid	
	(3)	Increase (decrease) in unearned premium reserve	

(4,) Earned ((1) + (2) - (3))	•••••••••••••••••••••••••••••••••••••••	:		433624	12
b Be	enefit charges:	en gergere en				
(1)) Claims paid	3	782	2551		

- (2) Increase (decrease) in claim reserves
- (4) Claims charged

9

Official Use Only

C	Ren	nainder	of premium:		
	(1)	Reten	tion charges (on an accrual basis)		
		(A) C	Commissions		
		(B) A	administrative service or other fees	356439	,
		(C) C	Other specific acquisition costs		
		(D) C	Other expenses		
		(E) T	axes		
		(F) C	charges for risks or other contingencies		
		(G) C	other retention charges		
		(H) To	otal retention		356439
	(2)		nds or retroactive rate refunds.		336 737
	.,		e amounts were 1) paid in cash, or 2) credited.)		
d			olicyholder reserves at end of year: at held to provide benefits after retirement		
	(2)	Claim :	reserves		400000
	(3)	Other i	reserves		
9	Divid (Do	lends o not incli	r retroactive rate refunds due. ude amount entered in c(2).)		
			nce-rated contracts:		
3	Total	premiu	ms or subscription charges paid to carrier		
)	If the	carrier	r, service, or other organization incurred any specific costs n with the acquisition or retention of the contract or policy, eported in Part I, item 2 above, report amount		

Form **5500**

Department of the Treasury
Internal Revenue Service
Department of Labor
Pension and Welfare Benefits
Administration
Pension Benefit
Guaranty Corporation

Annual Return/Report of Employee Benefit Plan

This form is required to be filed under sections 104 and 4065 of the Employee Retirement Income Security Act of 1974 (ERISA) and sections 6047(e), 6057(b), and 6058(a) of the Internal Revenue Code (the Code).

Pension Benefit
Guaranty Corporation

Complete all entries in accordance with the instructions to the Form 5500.

Part I Annual Report Identification Information

Official Use Only

OMB Nos. 1210-0110 / 1210-0089

2002

This Form is Open to Public Inspection.

For the calendar plan y or fiscal plan year begin	ear 2002 nning	10 01	2002	and	l ending	09	30		20	03
A This return/report is for:	(1)	a multiemployer plan;		(3)	a multip	ole-employe	r plan; or			
	(2)	a single-employer pla a multiple-employer p		(4)	a DFE	(specify)	•••••••••••••••••••••••••••••••••••••••			
B This return/report is:	(1)	the first return/report	filed for the plan;	(3)	the fina	il return/repo	ort filed for t	he plan	1;	
	(2)	an amended return/re	port;	(4)		plan year re	•			
C If the plan is a collective	ly-bargained p	olan, check here	••••••		less tn	an 12 monti	ns). 		▶	
1a Name of plan		n — enter all reques			<i>)</i>					
1b Three-digit plan numb	er (PN) ▶	504	1c Eff	ective date	of plan	07	01	/	96	6
Caution: A penalty for the Under penalties of perjury schedules, statements and a knowledge and belief, it is tr Signature of plan administr	v and other peattachments, a rue, correct ar rator	enalties set forth in the in as well as the electronic and complete.	nstructions, I declar e version of this re	assessed i	unless reas	ed this return ng filed elec	use is estab n/report, incl tronically, a	olished. Iuding a	accomp he bes	panying t of my
SIGN HERE (as plan administrator	ron		Date	04	20	2	00	4
		= W/LK/	NSON							
Signature of employer/plan	sponsor/DF		. . .							
SIGN HERE 🕨	landa	w & Theke	noon	•	Date	04	20	2	00	4
Type or print name of inc	dividual signing	as employer, plan sponsor	or DFE							
b CANDAC	CE P	= WILKI	NSON				. /			
For Paperwork Reduction A	Act Notice an	d OMB Control Numbe	ers, see the instru	ctions for	Form 5500). Cat. N	lo. 13500F	Form	ı 550 0	(2002)

		Official Use Only
2a	Plan sponsor's name and address (employer, if for single-employer plan) (Address should	
1)	BECHTEL BWXT IDAHO, LL	
2)	CIO CANDACE F WILKINSON	J
3)	PO BOX 1625 1955 FREEN	IONT AVE
4)	IDAHO FALLS	2b Employer Identification Number (EIN
5)	ID 83415-3200	94 3323797
6)	2c Sponsor's telephone number	208 526 0066
7)	Haribor	2d Business code (see instructions) 54/990
8)		(see instructions) J / / / C
9)		
3a	Plan administrator's name and address (If same as plan sponsor, enter "Same")	
1)	SAME	
٠,		
2)	c / o	
-, 3)		
-		
4)		3b Administrator's EIN
5)		
6)		3c Administrator's telephone number
7)	Mahamana at Managara at Managa	
4	If the name and/or EIN of the plan sponsor has changed since the last return/report filed to number from the last return/report below:	or this plan, enter the name, EIN and the plan

b EIN

c PN



1084

5834

5834

5 Preparer information (optional)

Name (including firm name, if applicable) and address

2)

1)

3)

4)

5)

6)

b EIN

c Telephone number

Number of participants as of the end of the plan year (welfare plans complete only lines 7a, 7b, 7c, and 7d)

a Active participants

b Retired or separated participants receiving benefits.....

c Other retired or separated participants entitled to future benefits.....

d Subtotal. Add lines 7a, 7b, and 7c

e Deceased participants whose beneficiaries are receiving or are entitled to receive benefits.....

g Number of participants with account balances as of the end of the plan year (only defined

h Number of participants that terminated employment during the plan year with accrued benefits that were less than 100% vested.....

f Total. Add lines 7d and 7e

contribution plans complete this item)

I if any participant(s) separated from service with a deferred vested benefit, enter the number of separated participants required to be reported on a Schedule SSA (Form 5500).....

8	Benefits	provided	under	the	plan	(complete	8a	and a	Bb. a	s ann	licable

- Pension benefits (check this box if the plan provides pension benefits and enter below the applicable pension feature codes from the List of Plan Characteristics Codes printed in the instructions):
- b Welfare benefits (check this box if the plan provides welfare benefits and enter below the applicable welfare feature codes from the List of Plan Characteristics Codes printed in the instructions):

4 A

- 9a Plan funding arrangement (check all that apply)

 (1) X Insurance

 (2) Code section 412(i) insurance contracts

 (3) Trust

 (4) X General assets of the sponsor

 9b Plan benefit arrangement (check all that apply)

 (1) X Insurance

 (2) Code section 412(i) insurance contracts

 (3) Trust

 (4) X General assets of the sponsor
- 10 Schedules attached (Check all applicable boxes and, where indicated, enter the number attached. See instructions.)

a Pension Benefit Schedules

- 1) R (Retirement Plan Information)
- 2) T (Qualified Pension Plan Coverage Information)

If a Schedule T is not attached because the plan is relying on coverage testing information for a prior year, enter the year

a prior year, enter the year

3)

4)

5)

- B (Actuarial Information)
- E (ESOP Annual Information)
- SSA (Separated Vested Participant Information)

b Financial Schedules

5)

6)

7)

- 1) H (Financial Information)
- 2) I (Financial Information--Small Plan)
 - X DD / A (Insurance Information)
 - C (Service Provider Information)
 - D (DFE/Participating Plan Information)
 - G (Financial Transaction Schedules)
 - P (Trust Fiduciary Information)



SCHEDULE A (Form 5500)

Department of the Treasury Internal Revenue Service Department of Labor

Pension and Welfare Benefits Administration

Pension Benefit Guaranty Corporation

Insurance Information

This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974.

File as an attachment to Form 5500.

Insurance companies are required to provide this information pursuant to ERISA section 103(a)(2).

Official Use Only

OMB No. 1210-0110

This Form is Open to Public Inspection.

For calendar plan year 2002 or fiscal plan year beginning

01 2002

and ending

09

2003

A Name of plan

INEEL HEALTH CARE PLAN

В Three-digit plan number

504

C Plan sponsor's name as shown on line 2a of Form 5500

BECHTEL BWXT IDAHO, LLC

D **Employer Identification Number**

3323797

Part I Information Concerning Insurance Contract Coverage, Fees, and Commissions

Provide information for each contract on a separate Schedule A. Individual contracts grouped as a unit in Parts II and III can be reported on a single Schedule A.

- 1 Coverage:
- Name of insurance carrier

VISION SERVICE PLAN

0339119 82 (b) EIN

(c) NAIC code

41183

Contract or identification number

12165723

Approximate number of persons covered at end of policy or contract year

5967

Policy or contract year

(f) From

01 01 2002

31 2002

Insurance fees and commissions paid to agents, brokers and other persons. Enter the total fees and total commissions below and list agents, brokers and other persons individually in descending order of the amount paid in the items on the following page(s) in Part I.

Totals

Total amount of commissions paid

Total fees paid / amount

For Paperwork Reduction Act Notice and OMB Control Numbers, see the instructions for Form 5500. Cat. No. 135051 Schedule A (Form 5500) 2002

- (a) Name and address of the agents, brokers or other persons to whom commissions or fees were paid
- (b) Amount of commissions paid

(c) Fees paid / Amount

(e) Organization code

- (d) Fees paid / Purpose
- (a) Name and address of the agents, brokers or other persons to whom commissions or fees were paid
- (b) Amount of commissions paid

(c) Fees paid / Amount

(e) Organization code

- (d) Fees paid / Purpose
- (a) Name and address of the agents, brokers or other persons to whom commissions or fees were paid
- (b) Amount of commissions paid

(c) Fees paid / Amount

(e) Organization

(d) Fees paid / Purpose



Schedule	Δ	/Form	5500\	2002
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Page 3

Official Use Only

Part		I
------	--	---

Investment and Annuity Contract Information

Where individual contracts are provided, the entire group of such individual contracts with each carrier may be treated as a unit for purposes of this report.

- 3 Current value of plan's interest under this contract in the general account at year end
- 4 Current value of plan's interest under this contract in separate accounts at year end
- 5 Contracts With Allocated Funds
- a State the basis of premium rates
- b Premiums paid to carrier
- c Premiums due but unpaid at the end of the year
- e Type of contract
- individual policies
- (2)

group deferred annuity

(3) other (specify below)

(1)

f If contract purchased, in whole or in part, to distribute benefits from a terminating plan check here

Schedule	٨	/Earm	FFOO	0000
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Page 4

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6 a	Cor	ntracts With Unallocated Funds (Do not inclined of contract	ude portions of these contracts maintained in se	parate acc	counts)
u	iyp.	e or contract			
	(1)	deposit administration (2)	immediate participation guarantee	(3)	guaranteed investment
	(4)	other (specify below)			
		, , , , , , , , , , , , , , , , , , , ,			
•		·			
.	Dala	anne at the sector is			
b	Dala	ance at the end of the previous year			
C		litions:			
	(1)	Contributions deposited during the year	·······		
	(2)	Dividends and credits			
	/2 1	Intercet are discalable to a			
	(3)	Interest credited during the year	······································		
	(4)	Transferred from separate account			
	(5)	Other (specify below)			
	. ,	, , , , , , , , , , , , , , , , , , , ,	······································		
>					
	(6)	Tabel and listens			
	(6)	Total additions	······································		
		Il of balance and additions (add b and c (6)))		
Ī	(1)	Disbursed from fund to pay benefits or			
		purchase annuities during year			
	(2)	Administration charge made by carrier	•••••		
	(3)	Transferred to separate account	·······		
	(4)	Other (specify below)			
▶					
	(5)	Total deductions			
					/
f	Bala	ance at the end of the current year (subtrac	at e(5) from d)		
		, ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,			
		0	5 0 2 A A 0 4 0	٧	
				-	



Schedule A (Form 550	00) 20	02
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Page 5

Official Use Only

Part III Welfare Benefit Contract Information

If more than one contract covers the same group of employees of the same employer(s) or members of the same employee organization(s), the information may be combined for reporting purposes if such contracts are experience-rated as a unit. Where individual contracts are provided, the entire group of such individual contracts with each carrier may be treated as a unit for purposes of this report.

7 Benefit and contract type (check all applicable boxes)

(a)	Health (other than dental or vision)	(b)	Dental	(c)	X	Vision	(d)	Life Insurance
(e)	Temporary disability (accident and sickness)	(f)	Long-term disability	(g)		Supplemental unemployment	(h)	Prescription drug
(i)	Stop loss (large deductible)	(I)	HMO contract	(k)		PPO contract	(1)	Indemnity contract
(m)	Other (specify below)							

8	Experience-rated	contracts
---	------------------	-----------

Pren	niums:				
(1)	Amount received				
(2)	Increase (decrease) in amount due but unpaid				
(3)	Increase (decrease) in unearned premium reserve				
(4)	Earned ((1) + (2) - (3))	 •••••	•••••	••••	••••
Bene	efit charges:				

(1) Claims paid

(2)	Increase (decrease) in claim reserves		
(3)	Incurred claims (add (1) and (2))	······································	······································

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C	Ren	mainder of premium:	
	(1)	Retention charges (on an accrual basis)	
		(A) Commissions	
		(B) Administrative service or other fees	
		(C) Other specific acquisition costs	
		(D) Other expenses	
		(E) Taxes	
		(F) Charges for risks or other contingencies	
		(G) Other retention charges	
			*
		(H) Total retention	
	(2)	Dividends or retroactive rate refunds.	
		(These amounts were 1) paid in cash, or 2) credited.)	
d	Stat	tus of policyholder reserves at end of year:	
		Amount held to provide benefits after retirement	
	(0)	Claim near man	
	(2)	Claim reserves	
	(3)	Other reserves	
8		idends or retroactive rate refunds due.	
	(DO	o not include amount entered in c(2).)	
9	Non	nexperience-rated contracts:	
9	Tota	al promiume or subscription observes noid to corrier	457298
a	1016	al premiums or subscription charges paid to carrier	731210
h	If th	ne carrier, service, or other organization incurred any specific costs	1
_	in c	connection with the acquisition or retention of the contract or policy,	
		er than reported in Part I, item 2 above, report amount	
	ope	ecify nature of costs below	
			en e



SCHEDULE C (Form 5500)

Department of the Treasury Internal Revenue Service

Department of Labor Pension and Welfare Benefits Administration

Pension Benefit Guaranty Corporation

For calendar plan year 2002 or fiscal plan year beginning

Service Provider Information

This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974.

File as an attachment to Form 5500.

2002

Official Use Only

OMB No. 1210-0110

This Form is Open to Public Inspection.

A Name of plan INEEL HEALTH CARE PLAN

C Plan sponsor's name as shown on line 2a of Form 5500

B

and ending

Three-digit plan number

504

2003

Employer Identification Number

94 3323797

30

BECHTEL BWXT IDAHO, LLC

Part I Service Provider Information (see instructions)

- Enter the total dollar amount of compensation paid by the plan to all persons, other than those listed below, who received compensation during the plan year:
- On the first item below list the contract administrator, if any, as defined in the instructions. On the other items, list service providers in descending order of the compensation they received for the services rendered during the plan year. List only the top 40. 103-12 IEs should enter N/A in (c) and (d).
 - (a) Name

AETNA US HEALTHCARE

(b) Employer identification number (see instructions)

06 6033492

1801985

Contract administrator

(c) Official plan position

Relationship to employer, employee organization, or person known to be a party-in-interest

Gross salary or allowances paid by plan

(f) Fees and commissions paid by plan

(g) Nature of service code(s)

(see instructions)

12

(a) Name

(d)

ECKERD HEALTH SERVICES

(b) Employer identification number (see instructions)

51 0353040

(c) Official plan position

Relationship to employer, employee organization, or person known to be a party-in-interest

CONTRACT ADMINISTRATOR

CLAIMS PROCESSING

Gross salary or allowances paid by plan

(f) Fees and commissions paid by plan

(g) Nature of service code(s)

instructions)

40631

For Paperwork Reduction Act Notice and OMB Control Numbers, see the instructions for Form 5500. Cat. No. 13515E Schedule C (Form 5500) 2002

(a) Name

CIGNA BEHAVIORAL HEALTH

(b) Employer identification number (see instructions)

41 1648670

(c) Official plan position

CONTRACT ADMINISTRATOR

(d) Relationship to employer, employee organization, or person known to be a party-in-interest

CLAIMS PROCESSING

(e) Gross salary or allowances paid by plan

(f) Fees and commissions paid by plan

(g) Nature of service code(s)
(see /)

179771

(a) Name

- (b) Employer identification number (see instructions)
- (c) Official plan position
- (d) Relationship to employer, employee organization, or person known to be a party-in-interest
- (e) Gross salary or allowances paid by plan
- (f) Fees and commissions paid by plan
- (g) Nature of service code(s)

(see instructions)

- (a) Name
- (b) Employer identification number (see instructions)
- (c) Official plan position
- (d) Relationship to employer, employee organization, or person known to be a party-in-interest
- (e) Gross salary or allowances paid by plan
- (f) Fees and commissions paid by plan
- (g) Nature of service code(s)

(see instructions)

- (a) Name
- (b) Employer identification number (see instructions)
- (c) Official plan position
- (d) Relationship to employer, employee organization, or person known to be a party-in-interest
- (e) Gross salary or allowances paid by plan
- (f) Fees and commissions paid by plan
- (g) Nature of service code(s) (see instructions)



<u> </u>		·•• ·	
(a)	Schedule C (Form 5500) 2002 Part II Termination Information	Page 3 on On Accountants and Enrolled Actuaries (see instructions)	Official Use Only
Name (b)	EIN	(c) Position	
(d) Address			
(e)	Telephone No.		
E X P L A			
N A T I O N			
(a)			
Name (b)	EIN	(c) Position	
(d) Address			
(e)	Telephone No.		
E X P L			
A N A T I O N			



Form **5500**

Annual Return/Report of Employee Benefit Plan

Official Use Only OMB Nos. 1210-0110 / 1210-0089

Department of the Treasury Internal Revenue Service Department of Labor Pension and Welfare Benefits Administration

This form is required to be filed under sections 104 and 4065 of the Employee Retirement Income Security Act of 1974 (ERISA) and sections 6047(e), 6057(b), and 6058(a) of the Internal Revenue Code (the Code).

Pension Benefit **Guaranty Corporation** ► Complete all entries in accordance with the instructions to the Form 5500.

This Form is Open to Public Inspection.

Part I Annual Repo	rt Identifi	cation In	formation	n					•	
For the calendar plan ye or fiscal plan year begin	ar 2002	10	01	2002	ε	and ending	09	30	2003	3
A This return/report is for:	(1)	a multiem	ployer plan;		(3)	a multiple	-employer	plan; or		
	(2)		mployer plar -employer pl	n (other than an);	(4)	a DFE (sį	oecify)	*************		
B This return/report is:	(1)	the first re	turn/report f	iled for the plan;	(3)	the final r	eturn/repo	rt filed for the	e plan;	
	(2)	an amend	ed return/re	port;	(4)	•	an year re 12 month	turn/report		
C If the plan is a collectively	-bargained p	lan, check t	nere		••••••	(1035 11101)		s). 	>	
Part II Basic Plan In 1a Name of plan SEVERA				eted information	.					
1b Three-digit plan numbe	er (PN) ▶	507	7	1c Effe	ctive o	late of plan	10	01	1987	
Type or print name of individual a CANDAC Signature of employer/plan a	and other pertachments, a e, correct and other stores.	nalties set fis well as the discomplete Thus as plan admin	orth in the inne electronic	nstructions, I declar e version of this ref	a that	I have aveninged	this return filed elect	/report, incluronically, and	uding accompanying to the best of m	g
Type or print name of individual by CANDAC	vidual signing a	as employer,	plan sponsor	or DFE		Date	<i>3 4</i>	/	<i>3.00</i>	
For Paperwork Reduction Ac	t Notice and	OMB Con	ntrol Numbe	rs, see the instru	tions	for Form 5500.	Cat. No	o. 13500F	Form 5500 (2002	<u>?</u>)

Official Use Only

2a	Plan sponsor's name and address	employer, if for single-employer plar	n) (Address should include room or suite no.)
----	---------------------------------	---------------------------------------	---

BECHTEL BWXT IDAHO,

C/O CANDACE F WILKINSON

PO BOX 1625 1955 FREEMONT AVE

IDAHO FALLS

2b Employer Identification Number (EIN)

ID 83415-3200

94 3323797

2c Sponsor's telephone number

208 526 0066

2d Business code (see instructions) 541990

9)

7)

Plan administrator's name and address (If same as plan sponsor, enter "Same")

SAME 1)

c/o2)

3)

3b Administrator's EIN

6)

3c Administrator's telephone number

7)

If the name and/or EIN of the plan sponsor has changed since the last return/report filed for this plan, enter the name, EIN and the plan number from the last return/report below:

Sponsor's name

EIN

c PN



5	Preparer	information	(optional)
---	----------	-------------	------------

Name (including firm name, if applicable) and address

2)

1)

3)

4)

5)

6)

Total number of participants at the beginning of the plan year

Number of participants as of the end of the plan year (welfare plans complete only lines 7a, 7b, 7c, and 7d)

e Deceased participants whose beneficiaries are receiving or are entitled to receive benefits.....

a Active participants

b Retired or separated participants receiving benefits.....

c Other retired or separated participants entitled to future benefits.....

d Subtotal. Add lines 7a, 7b, and 7c

f Total. Add lines 7d and 7e

g Number of participants with account balances as of the end of the plan year (only defined contribution plans complete this item)

h Number of participants that terminated employment during the plan year with accrued benefits that were less than 100% vested.....

I If any participant(s) separated from service with a deferred vested benefit, enter the number of separated participants required to be reported on a Schedule SSA (Form 5500).....

b EIN

Telephone number

5080

5004

5004

5004



Form	5500	(2002)
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Page 4

Official Use Only

3	Benefits	provided	under	the	plan	(complete	8a	and 8b,	as	applicable)
---	----------	----------	-------	-----	------	-----------	----	---------	----	------------	---

- a Pension benefits (check this box if the plan provides pension benefits and enter below the applicable pension feature codes from the List of Plan Characteristics Codes printed in the instructions):
- b X Welfare benefits (check this box if the plan provides welfare benefits and enter below the applicable welfare feature codes from the List of Plan Characteristics Codes printed in the instructions):

4I

9a	Plan funding arrangement (check all that apply)				Plan benefit arrangement (check all that apply)			
	(1)	Insurance		(1)		Insurance		
	(2)	Code section 412(i) insurance contracts		(2)		Code section 412(i) insurance contracts		
	(3)	Trust		(3)		Trust		
	(4)	General assets of the sponsor		(4)	Χ	General assets of the sponsor		

10 Schedules attached (Check all applicable boxes and, where indicated, enter the number attached. See instructions.)

			actions occurred ac	doi 10.)
a Pension Benefit	t Schedules	b Financial Sched	lules	
1)	R (Retirement Plan Information)	1)	н	(Financial Information)
2)	T (Qualified Pension Plan Coverage Information)	2)	l	(Financial InformationSmall Plan)
	ule T is not attached	3)	A	(Insurance Information)
coverage to	ne plan is relying on esting information for ir, enter the year	4)	С	(Service Provider Information)
	,	5)		(DFE/Participating Plan Information)
. 3)	B (Actuarial Information)			
4)	E (ESOP Annual Information)	6)	G	(Financial Transaction Schedules)
•		7)	P	(Trust Fiduciary Information)
5)	SSA (Separated Vested Participant Information)	•		,,



5500 Torm

Department of the Treasury
Internal Revenue Service
Department of Labor
Pension and Welfare Benefits
Administration
Pension Benefit
Guaranty Corporation

Annual Return/Report of Employee Benefit Plan

This form is required to be filed under sections 104 and 4065 of the Employee Retirement Income Security Act of 1974 (ERISA) and sections 6047(e), 6057(b), and 6058(a) of the Internal Revenue Code (the Code).

► Complete all entries in accordance with the instructions to the Form 5500.

Official Use Only

OMB Nos. 1210-0110 / 1210-0089

2002

This Form is Open to Public Inspection.

Part I Annual Repo	ort Identi	fication In	formatio	n						•	
For the calendar plan ye or fiscal plan year begin		10	01	20	02	an	d ending	09	30	20	003
A This return/report is for:	(1)	a multiem	ployer plan;			(3)	a multip	le-employer	plan; or		
	(2))	mployer pla -employer p		an	(4)	a DFE (specify)	······································		
B This return/report is:	(1)	the first re	eturn/report	filed for the	e plan;	(3)	the final	return/repor	t filed for the	plan;	
C If the plan is a collectivel	(2) v-hargained		led return/re	•		(4)	(less tha	plan year ret an 12 month:	s).		
											•
D if filing under an extension							information. (see instruction	ons)		•
Part II Basic Plan I 1a Name of plan	nformatio	on enter	all reque	sted info	ormatio	n.					
INEEL	AC	CIDE	ENT/	4 _	DE.	ATA	4 A1	D			
DISMEI			-	•		,	•				
DISME	OLI	CMEN	<i>,</i>		70						
							•				
		<i>E</i> 0 .	.					40	0 /	10	, ,
1b Three-digit plan numb	er (PN) ▶	50%	7		1c Eff	ective da	te of plan	09	01	19	66
Caution: A penalty for the											
Under penalties of perjury schedules, statements and a knowledge and belief, it is tr Signature of plan administr	attachments, ue, correct	, as well as t	he electroni	nstructions c version	s, I decla of this re	re that I I sturn/repo	have examine ort if it is beir	ed this return ng filed elect	report, incluration	ding according to the i	ompanying best of my
SIGN HERE	landa	ee S. a	Milken	rion)		Date	01	20	20	04:
Type or print name of inc	dividual signin	ig as plan admi	nistrator								
a CANDA	CE.	FW	1LK.	1 N S	ON						
Signature of employer/plan	sponsor/D	FE									
SIGN HERE	andas	w 6.7.	Vilken	ison			Date	04	20	20	04
Type or print name of inc	dividual signin	ng as employer,	plan sponsor	r or DFE							
b CANDA	CE	F W	ILK.	1 N S	ON						
For Paperwork Reduction A	Act Notice a	and OMB Co	ntrol Numb	ers, see t	he Instru	ctions f	or Form 5500	D. Cat. N	o. 13500F	Form 55	500 (2002

Official Use Only

28	Plan sponsor's name and addres	(employer, if for single-employer plan) (Address should include room or suite no).)
-----------	--------------------------------	--	-----

- BECHTEL BWXT IDAHO, LLC
- CIO. CANDACE F WILKINSON
- PO BOX 1625 1955 FREEMONT AVE
- IDAHO FALLS

2b Employer Identification Number (EIN)

ID 83415-3200

94 3323797

2c Sponsor's telephone number

208 526 0066

2d Business code (see instructions) 54/996

8)

9)

6)

7)

Plan administrator's name and address (If same as plan sponsor, enter "Same")

- SAME 1)
- 2)

3)

5)

6) 7) 3b Administrator's EIN

3c Administrator's telephone number

- If the name and/or EIN of the plan sponsor has changed since the last return/report filed for this plan, enter the name, EIN and the plan number from the last return/report below:
- Sponsor's name

EIN

c PN



EIN

3821

3821

5	Preparer	information	(optional)
•	i icpaioi	II II OI III ALIOI I	(Upilional

Name (including firm name, if applicable) and address

1)

2)

3)

4)

6)

5)

Telephone number

3872 Total number of participants at the beginning of the plan year

Number of participants as of the end of the plan year (welfare plans complete only lines 7a, 7b, 7c, and 7d)

a Active participants

b Retired or separated participants receiving benefits.....

c Other retired or separated participants entitled to future benefits.....

3821 d Subtotal. Add lines 7a, 7b, and 7c

e Deceased participants whose beneficiaries are receiving or are entitled to receive benefits.....

1 Total. Add lines 7d and 7e

g Number of participants with account balances as of the end of the plan year (only defined contribution plans complete this item)

h Number of participants that terminated employment during the plan year with accrued benefits that were less than 100% vested

I If any participant(s) separated from service with a deferred vested benefit, enter the number of separated participants required to be reported on a Schedule SSA (Form 5500).....

Form	5500	(2002)
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Page 4

Official Use Only

8	Benefits	provided	under	the	plan	(complete	8a	and 8b	. as	applicable	٠,
		•				COCHIPIOLO	u	and ob	. as	avvilleani	٠

- Pension benefits (check this box if the plan provides pension benefits and enter below the applicable pension feature codes from the List of Plan Characteristics Codes printed in the instructions):
- b Welfare benefits (check this box if the plan provides welfare benefits and enter below the applicable welfare feature codes from the List of Plan Characteristics Codes printed in the instructions):

4Q

5)

10 Schedules attached (Check all applicable boxes and, where indicated, enter the number attached. See instructions.)

a Pension Benefit Schedules 1) R (Retirement Plan Information) 2) T (Qualified Pension Plan Coverage Information) If a Schedule T is not attached because the plan is relying on coverage testing information for a prior year, enter the year 3) B (Actuarial Information) 4) E (ESOP Annual Information)

SSA (Separated Vested

Participant Information)

b	Fin	anciai S	chedules		,
	1)			Н	(Financial Information)
	2)			ı	(Financial InformationSmall Plan)
	3)	X	001	A	(Insurance Information)
	4)			С	(Service Provider Information)
	5)	11 - 12 - 1	· · · · · · · · · · · · · · · · · · ·	D	(DFE/Participating Plan Information)
	6)			G	(Financial Transaction Schedules)
	7)			P	(Trust Fiduciary Information)



SCHEDULE A (Form 5500)

Department of the Treasury Internal Revenue Service

Department of Labor Pension and Welfare Benefits Administration

Pension Benefit Guaranty Corporation

For calendar plan year 2002 or fiscal plan year beginning

Insurance Information

This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974.

File as an attachment to Form 5500.

Insurance companies are required to provide this information pursuant to ERISA section 103(a)(2).

Official Use Only

OMB No. 1210-0110

This Form is Open to Public Inspection.

A Name of plan INEEL ACCIDENTAL DEATH AND DISMEMBERMENT PLAN

C Plan sponsor's name as shown on line 2a of Form 5500

В Three-digit plan number

09

50a

2003

and ending

Employer Identification Number

3323797 94

30

BECHTEL BUXT IDAHO, LLC Part I Information Concerning Insurance Contract Coverage, Fees, and Commissions

Provide information for each contract on a separate Schedule A. Individual contracts grouped as a unit in Parts II and III can be reported on a single Schedule A.

- 1 Coverage:
- (a) Name of insurance carrier

TRANSAMERICA OCCIDENTAL LIFE INSURANCE

10 01 2002

95 1060502

(c) NAIC code

67121

Contract or identification number

05228082

Approximate number of persons covered at end of policy or contract year

3993

Policy or contract year

(f) From

01 01 2002

2002 31

Insurance fees and commissions paid to agents, brokers and other persons. Enter the total fees and total commissions below and list agents, brokers and other persons individually in descending order of the amount paid in the items on the following page(s) in Part I.

Totals

Total amount of commissions paid

Total fees paid / amount

 \mathcal{D}

For Paperwork Reduction Act Notice and OMB Control Numbers, see the instructions for Form 5500. Cat. No. 135051 Schedule A (Form 5500) 2002



(a) Name and address of the agents, brokers or other persons to whom commissions or fees were paid

(b) Amount of commissions paid

(c) Fees paid / Amount

(e) Organization code

(d) Fees paid / Purpose

(a) Name and address of the agents, brokers or other persons to whom commissions or fees were paid

(b) Amount of commissions paid

(c) Fees paid / Amount

(e) Organization code

(d) Fees paid / Purpose

(a) Name and address of the agents, brokers or other persons to whom commissions or fees were paid

(b) Amount of commissions paid

(c) Fees paid / Amount

e) Organization

(d) Fees paid / Purpose



Schedule	Δ	/Form	5500	2002
OCHRONIA	~	(FOITH	DOUU,	2002

Page 3

Official Use Only

Part	Ш
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Investment and Annuity Contract Information

Where individual contracts are provided, the entire group of such individual contracts with each carrier may be treated as a unit for purposes of this report.

- 3 Current value of plan's interest under this contract in the general account at year end
- 4 Current value of plan's interest under this contract in separate accounts at year end
- 5 Contracts With Allocated Funds
- a State the basis of premium rates
- b Premiums paid to carrier
- c Premiums due but unpaid at the end of the year
- e Type of contract
- individual policies
- (2)

group deferred annuity

(3) other (specify below)

(1)

f If contract purchased, in whole or in part, to distribute benefits from a terminating plan check here

	l	Schedule A (Form 5500) 200	02		Page 4	
6	Co a Typ	ontracts With Unallocated Funds (D pe of contract	o not include	portions of these contracts maintained in	n separate acc	ounts)
	(1	deposit administration	(2)	immediate participation guarantee	(3)	gua
	(4	other (specify below)				
•	•	•				
b	Bal	ance at the end of the previous ye	ar			
c	Add (1)	ditions: Contributions deposited during th	e year			
	(2)	Dividends and credits	••••••			
	(3)	Interest credited during the year	••••••	•		
	(4)	Transferred from separate accour	nt			
	(5)	Other (specify below)	••••••			
>	•					
	(6)	Total additions				
d e	Tota Ded	al of balance and additions (add bal	and c <i>(6)</i>)			
	(1)	Disbursed from fund to pay benef purchase annuities during year	its or			
	(2)	Administration charge made by ca	arrier			
	(3)	Transferred to separate account	***************************************			
	(4)	Other (specify below)		-		

(5) Total deductions

f Balance at the end of the curren	t year (subtract e(5) from d)
L	0 5 0 2 A A 0 4 0 V

Official Use Only

guaranteed investment

Part III

Welfare Benefit Contract Information

If more than one contract covers the same group of employees of the same employer(s) or members of the same employee organization(s), the information may be combined for reporting purposes if such contracts are experience-rated as a unit. Where individual contracts are provided, the entire group of such individual contracts with each carrier may be treated as a unit for purposes of this report.

7 Benefit and contract type (check all applicable boxes)

(a)		Health (other than dental or vision)	(b)	Dental	(c)	Vision	(d)	Life Insurance
(e)		Temporary disability (accident and sickness)	(f)	Long-term disability	(g)	Supplemental unemployment	(h)	Prescription drug
(1)		Stop loss (large deductible)	(i)	HMO contract	(k)	PPO contract	(I)	Indemnity contract
(m)	X	Other (specify below)						

· ACCIDENTAL DEATH AND DISMEMBERMENT

8 Experience-rated contracts

a Premiums:

b

(1)	Amount received	
(2)	Increase (decrease) in amount due but unpaid	
(3)	Increase (decrease) in unearned premium reserve	A COMPANY OF A CASE
(4)	Earned ((1) + (2) - (3))	
	efit charges: Claims paid	
(2)	Increase (decrease) in claim reserves	
(3)	Incurred claims (add (1) and (2))	
(4)	Claims charged	

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Re	maind	er of premium:			
(1)	Ret	ention charges (on an accrual basis)			
	(A)	Commissions			
	(B)	Administrative service or other fees			
	(C)	Other specific acquisition costs			
	(D)	Other expenses			
	(E)	Taxes			
	(F)	Charges for risks or other contingencies			
	(G)	Other retention charges			
		Total retention			
10					
(2	<i>)</i> DIV	idends or retroactive rate refunds.			
	(T)	ese amounts were 1) paid in cash, or 2) credited.)			
		to the body of the same			
		f policyholder reserves at end of year: ount held to provide benefits after retirement			
,	,				
(2) Cla	im reserves			
(3) Oti	ner reserves			
a Di	viden	ds or retroactive rate refunds due.			
		include amount entered in c(2).)			
N	onexp	erience-rated contracts:			
a To	tal pr	emiums or subscription charges paid to carrier	,	461	474
o If	the c	rrier, service, or other organization incurred any specific costs			
in	conn	ection with the acquisition or retention of the contract or policy,			
		an reported in Part I, item 2 above, report amountnature of costs below			
J		Titulate of books point			

5500 5orm

Department of the Treasury
Internal Revenue Service
Department of Labor
Pension and Welfare Benefits
Administration
Pension Benefit

Annual Return/Report of Employee Benefit Plan

This form is required to be filed under sections 104 and 4065 of the Employee Retirement Income Security Act of 1974 (ERISA) and sections 6047(e), 6057(b), and 6058(a) of the Internal Revenue Code (the Code).

► Complete all entries in accordance with the instructions to the Form 5500.

Official Use Only

OMB Nos. 1210-0110 / 1210-0089

2002

This Form is Open to Public Inspection.

Guaranty Corporation					tions to the	Forr	n 5500.		Publ	ic Inspection.
Part I Annual Repo	rt Id	entifi	cation l	nformation	1					
For the calendar plan year or fiscal plan year begin		02	10	01	2002		and ending	09	30	2003
A This return/report is for:	(1)		a multier	mployer plan;	•	(3)	a multipl	e-employer p	olan; or	
	(2)	X		employer plar e-employer pl		(4)	a DFE (specify)	······································	
B This return/report is:	(1)		the first	return/report f	filed for the plan;	(3)	the final	return/report	t filed for the	ə plan;
	(2)		an amen	ded return/re	port;	(4)		olan year ret	•	
C If the plan is a collectively	-barga	ined p	lan, check	here	**************************	•••••		ın 12 months		
D If filing under an extension							ed information. (s	see instructio	ns)	>
Part II Basic Plan Ir	form	atior	ı – ente	r all reques	sted informatio	n.				
1a Name of plan										
INEEL LONG TERM DISABILITY										
INSURA	INSURANCE PLAN									
							•			
								"		
1b Three-digit plan numbe	er (PN)	· •	50	5	1c Ef	fective	date of plan	12	01	1968
Caution: A penalty for the la	ate or	incom	plete filin	g of this retu	ırn/report will be	asses	sed unless reas	onable caus	se is establ	ished.
Under penalties of perjury schedules, statements and at knowledge and belief, it is tru Signature of plan administra	and of tachm e, cor	ther pe	nalties set	t forth in the in	nstructions I decla	are the	ıt I have evamine	d this return	report inch	idina accompanyina
SIGN HERE	zna	laci	15.	Telken	ison		Date	04	20	2004
Type or print name of indi	vidual :	signing	as plan adr	ministrator			-			
a CANDAC	$\boldsymbol{\mathcal{E}}$	F	W	ILKI	NSON	7				
Signature of employer/plan	spons	or/DFI	Ξ.		•					
SIGN HERE	an	das	es Es	Thek	maon		Date	04	20	2004
Type or print name of indi	vidual :	signing	as employe	r, plan sponsor	or DFE					
b CANDAC	E	F	= W	ILKI	NSON					
For Paperwork Reduction A	ct Not	ice an	d OMB C	ontrol Numbe	ers, see the instr	uçtion	s for Form 5500	. Cat. No	. 13500F	Form 5500 (2002)
			0	1 0 :	2 A A C)1	0 0			

Official Use Only

2a	Plan sponsor's name and address	(employer if for single-employer ni-	an) (Address should include room or suite no.)
A.Q.	rian sponsors name and address	(Gillbiolei' ii ioi ailidie-ellibiolei bi	any (Address should include room or suite no.)

BECHTEL BWXT IDAHO, LLC

- C/O CANDACE F WILKINSON
- PO BOX 1625 1955 FREEMONT AVE
- IDAHO FALLS

2b Employer Identification Number (EIN)

ID 83415-3200

94 3323797

2c Sponsor's telephone number

208 526 0066

2d Business code

Business code (see instructions) 541990

8)

6)

7)

9)

- За Plan administrator's name and address (If same as plan sponsor, enter "Same")
- SAME 1)
- c/o2)

3)

4)

3b Administrator's EIN

5) 6)

3c Administrator's telephone number

7)

- If the name and/or EIN of the plan sponsor has changed since the last return/report filed for this plan, enter the name, EIN and the plan number from the last return/report below:
- Sponsor's name
- EIN

c PN



Preparer information (optional)	5	Preparer	information	(0	ptional
---------------------------------	---	----------	-------------	----	---------

Name (including firm name, if applicable) and address

2)

1)

3) b EIN

4)

5) c Telephone number

6)

Number of participants as of the end of the plan year (welfare plans complete only lines 7a, 7b, 7c, and 7d)

c Other retired or separated participants entitled to future benefits.....

e Deceased participants whose beneficiaries are receiving or are entitled to receive benefits

g Number of participants with account balances as of the end of the plan year (only defined contribution plans complete this item)

h Number of participants that terminated employment during the plan year with accrued benefits that were less than 100% vested......

I If any participant(s) separated from service with a deferred vested benefit, enter the number of separated participants required to be reported on a Schedule SSA (Form 5500)



j	Benefits provided	under	the	plan	(complete	8a	and 8b	, as	applicable	3)
---	-------------------	-------	-----	------	-----------	----	--------	------	------------	----

- Pension benefits (check this box if the plan provides pension benefits and enter below the applicable pension feature codes from the List of Plan Characteristics Codes printed in the instructions):
- b Welfare benefits (check this box if the plan provides welfare benefits and enter below the applicable welfare feature codes from the List of Plan Characteristics Codes printed in the instructions):

411

		g arrangement (check all that apply)	9b	Plan	Plan benefit arrangement (check all that apply)			
(1)	X	Insurance		(1)		Insurance		
(2)		Code section 412(i) insurance contracts		(2)		Code section 412(i) insurance contracts		
(3)		Trust		(3)		Trust		
(4)		General assets of the sponsor		(4)		General assets of the sponsor		

10 Schedules attached (Check all applicable boxes and, where indicated, enter the number attached. See instructions.)

a Pension Benefit Schedules b Financial Schedules 1) (Retirement Plan Information) 1) H (Financial Information) 2) (Qualified Pension Plan 2) (Financial Information--Small Plan) Coverage Information) X 001 3) (Insurance Information) If a Schedule T is not attached because the plan is relying on 4) coverage testing information for (Service Provider Information) a prior year, enter the year 5) (DFE/Participating Plan Information) 3) (Actuarial Information) 6) (Financial Transaction Schedules) 4) (ESOP Annual Information) 7) (Trust Fiduciary Information) 5) SSA (Separated Vested Participant Information)



SCHEDULE A (Form 5500)

Department of the Treasury Internal Revenue Service

Department of Labor Pension and Welfare Benefits Administration

Pension Benefit Guaranty Corporation

For calendar plan year 2002 or fiscal plan year beginning

Insurance Information

This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974.

▶ File as an attachment to Form 5500.

Insurance companies are required to provide this information pursuant to ERISA section 103(a)(2). Official Use Only

OMB No. 1210-0110

2002

This Form is Open to Public Inspection.

10 01 2002

and ending

•

30

2003

A Name of plan

INEEL LONG TERM DISABILITY INSURANCE PLAN

C Plan sponsor's name as shown on line 2a of Form 5500

BECHTEL BUXT FDAHO, LLC

B Three-digit plan number

505

Employer Identification Number

94 3323797

Information Concerning Insurance Contract Coverage, Fees, and Commissions

Provide information for each contract on a separate Schedule A. Individual contracts grouped as a unit in Parts II and III can be reported on a single Schedule A.

- 1 Coverage:
- (a) Name of insurance carrier

CIGNA LIFE INSURANCE COMPANY OF NORTH AMERICA

(b) EIN 23 1503749

(c) NAIC code

65498

(d) Contract or identification number

LK 008044

(e) Approximate number of persons covered at end of policy or contract year

3960

Policy or contract year

(f) From

01 01 2002

(a) To

ノつ

7 /

2002

Insurance fees and commissions paid to agents, brokers and other persons. Enter the total fees and total commissions below and list agents, brokers and other persons individually in descending order of the amount paid in the items on the following page(s) in Part I.

Totals

Total amount of commissions paid

Total fees paid / amount

ク

1

For Paperwork Reduction Act Notice and OMB Control Numbers, see the instructions for Form 5500. Cat. No. 135051 Schedule A (Form 5500) 2002



- (a) Name and address of the agents, brokers or other persons to whom commissions or fees were paid
- (b) Amount of commissions paid

(c) Fees paid / Amount

(e) Organization code

- (d) Fees paid / Purpose
- (a) Name and address of the agents, brokers or other persons to whom commissions or fees were paid
- (b) Amount of commissions paid

(c) Fees paid / Amount

(e) Organization code

- (d) Fees paid / Purpose
- (a) Name and address of the agents, brokers or other persons to whom commissions or fees were paid
- (b) Amount of commissions paid

(c) Fees paid / Amount

(e) Organization code

(d) Fees paid / Purpose



Schedule	Α	(Form	5500	2002

Official Use Only

Part II

Investment and Annuity Contract Information

Where individual contracts are provided, the entire group of such individual contracts with each carrier may be treated as a unit for purposes of this report.

- 3 Current value of plan's interest under this contract in the general account at year end
- 4 Current value of plan's interest under this contract in separate accounts at year end
- 5 Contracts With Allocated Funds
- a State the basis of premium rates
- b Premiums paid to carrier
- c Premiums due but unpaid at the end of the year
- e Type of contract
- (1)

individual policies

(2)

group deferred annuity

(3) other (specify below)

f If contract purchased, in whole or in part, to distribute benefits from a terminating plan check here

Cobodula		/F	FF00\	0000
Schedule	А	(rorm	55001	2002

Page 4

(1)	deposit administration	(2)	immediate participation guarantee	(3)	guaranteed investment
(4)	other (specify below)				
	· ·				
Bala	ance at the end of the previous year	•••••			
Add	itions:				
(1)	Contributions deposited during the year	ear			
(2)	Dividends and credits	••••••			
(3)	Interest credited during the year				
(4)	Transferred from separate account				
(5)	Other (specify below)	************			
(6)	Total additions	••••••			
			,		
	I of balance and additions (add b and uctions:	i c <i>(6)</i>)			
(1)	Disbursed from fund to pay benefits	or			
	purchase annuities during year				
(2)	Administration charge made by carrie	ər			
(3)	Transferred to separate account	•••••			
(4)	Other (specify below)	•••••	-		
(E)	Total dadications				
(5)	Total deductions	••••••	***************************************		



Part III

Welfare Benefit Contract Information

If more than one contract covers the same group of employees of the same employer(s) or members of the same employee organization(s), the information may be combined for reporting purposes if such contracts are experience-rated as a unit. Where individual contracts are provided, the entire group of such individual contracts with each carrier may be treated as a unit for purposes of this report.

7 Benefit and contract type (check all applicable boxes)

(a)	Health (other than dental or vision)	(b)	,	Dental	(c)	Vision	(d)	Life Insurance
(e)	Temporary disability (accident and sickness)	(f)	X	Long-term disability	(g)	Supplemental unemployment	(h)	Prescription drug
(1)	Stop loss (large deductible)	(I)		HMO contract	(k)	PPO contract	(1)	Indemnity contract
(m)	Other (specify holow)							

8	Experience-rated	contracts

Prei	miums:	
(1)	Amount received	
(2)	Increase (decrease) in amount due but unpaid	
(3)	Increase (decrease) in unearned premium reserve	
(4)	Earned ((1) + (2) - (3))	
D	atta da una	

_	Donoit Graiges.					
	(1)	Claims paid	***************************************			

(2)	Increase	(decrease)	in	claim	reserves	

laims (add (1) and (2))
aims (add (1) and (2))

-	Ren	nainder of premium:	
	(1)	Retention charges (on an accrual basis)	
		(A) Commissions	
		(B) Administrative service or other fees	
		(C) Other specific acquisition costs	
		(D) Other expenses	
		(E) Taxes	
		(F) Charges for risks or other contingencies	
		(G) Other retention charges	
		(H) Total retention	
	(2)	Dividends or retroactive rate refunds.	••••
		(These amounts were 1)	
		(These amounts were 1) paid in cash, or 2) credited.)	
d	Statu	us of policyholder reserves at end of year:	
	(1)	Amount held to provide benefits after retirement	····
	(2)	Claim reserves	
	(3)	Other reserves	
_			•
е	(Do r	lends or retroactive rate refunds due. not include amount entered in c <i>(2)</i> .)	
			
9	None	experience-rated contracts:	
а	iotai	premiums or subscription charges paid to carrier	/ 322858
b	If the	carrier, service, or other organization incurred any specific costs	
	other	nnection with the acquisition or retention of the contract or policy, than reported in Part I, item 2 above, report amount	A CONTRACT OF THE PROPERTY OF
	Speci	ify nature of costs below	•••



Form **5500**

Annual Return/Report of Employee Benefit Plan

Official Use Only
OMB Nos. 1210-0110 / 1210-0089

Department of the Treasury Internal Revenue Service Department of Labor Pension and Welfare Benefits Administration

This form is required to be filed under sections 104 and 4065 of the Employee Retirement Income Security Act of 1974 (ERISA) and sections 6047(e), 6057(b), and 6058(a) of the Internal Revenue Code (the Code).

2002

Pension Benefit Guaranty Corporation ► Complete all entries in accordance with the instructions to the Form 5500.

This Form is Open to Public Inspection.

Part I Annual Repo	ort Identifi	cation In	formation	1						
For the calendar plan ye or fiscal plan year begin	ear 2002 ening	10	01	200	2	and ending	09	30	20	03
A This return/report is for:	(1)	a multiemp	ployer plan;	•	(3)	a multiple	e-employer į	olan; or		
	(2)		mployer plan employer pl	n (other than an);	(4)	a DFE (s	specify)	••••••		
B This return/report is:	(1)	the first re	turn/report f	iled for the pla	an; (3)	the final	return/repor	t filed for the	plan;	
	(2)	an amende	ed return/rep	port;	(4)	·	olan year ret n 12 months	•		
C If the plan is a collectively	y-bargained p	lan, check h	nere	•••••••					>	
Part II Basic Plan II 1a Name of plan	nformatio	n enter	all reques	sted inform	ation.			ns)	>	1
INEEL	LIF	E	NSU	LRAN	CE	PLAN	/			
						,	w.			
1b Three-digit plan numb	er (PN) ▶	503	3	,1 c	Effective	date of plan	07	01	19	66
Caution: A penalty for the Under penalties of perjury schedules, statements and a knowledge and belief, it is trusting Signature of plan administr	and other pe ttachments, a ue, correct a	nalties set fo	orth in the in	structions L	declare the	at I have evamine	d this return	report incl	idina acco	mpanying est of my
SIGN HERE	ndoce	16. TP.	ilkin	ion		Date	04	20	20	04
Type or print name of ind		-		_						
a CANDA	CE P	= W/	LKI	N50	N					
Signature of employer/plan	•	_								
SIGN HERE	andac	U 6.71	Weken	ion		Date	04	20	، د ل	04
Type or print name of ind	lividual signing	as employer,	plan sponsor	or DFE						
6 CANDAC	LE F	= W/	LKI	NSO	N					
For Paperwork Reduction A	ct Notice an	d OMB Con	ntrol Numbe	ers, see the l	nstruction	ns for Form 5500	. Cat. No	. 13500F	Form 55 6	00 (2002)
		0 1	1 0 2	2 A A	0 1	0 0				

1)	BECHTEL BWXT I	DAHO, LLO			
2)	CIO CANDACE F	WILKINSON	V		
3)	PO BOX 1625 1	955 FREE	MONT	AVE	
4)	IDAHO FALLS.		2b En	nployer Identificat	ion Number (El
5)	ID 83415-3200		94	4 332	379
6)	•	2c Sponsor's telephone number	208	526	0060
7)			2d Business (see instr	code uctions) 54	11990
8)					
9)					I

Plan sponsor's name and address (employer, if for single-employer plan) (Address should include room or suite no.)

3a Plan administrator's name and address (If same as plan sponsor, enter "Same")

1) SAME

2) C / C

3)

4)

3b Administrator's EIN

5)

3c Administrator's telephone number

7)

If the name and/or EIN of the plan sponsor has changed since the last return/report filed for this plan, enter the name, EIN and the plan number from the last return/report below:

a Sponsor's name

b EIN

c PN



Form	5500	(2002)
1 01111	3300	12002

Official Use Only

Name (including firm name, if applicable) and address

2)

1)

3)

b EIN

4)

5)

c Telephone number

6)

6 Total number of participants at the beginning of the plan year

6539

7 Number of participants as of the end of the plan year (welfare plans complete only lines 7a, 7b, 7c, and 7d)

a Active participants

c Other retired or separated participants entitled to future benefits

d Subtotal Add lines 7a, 7b, and 7c

f Total. Add lines 7d and 7e

4994

b Retired or separated participants receiving benefits.....

1465

6459

e Deceased participants whose beneficiaries are receiving or are entitled to receive benefits

6459

g Number of participants with account balances as of the end of the plan year (only defined

contribution plans complete this item)

h Number of participants that terminated employment during the plan year with accrued benefits that were less than 100% vested

I if any participant(s) separated from service with a deferred vested benefit, enter the number of separated participants required to be reported on a Schedule SSA (Form 5500)

Form	5500	(2002)
TOTAL	2200	IZUUZ

3	Benefits	provided	under t	he pla	n (com	piete 8a	and 8	b, as	applicable)
---	----------	----------	---------	--------	--------	----------	-------	-------	-------------

- Pension benefits (check this box if the plan provides pension benefits and enter below the applicable pension feature codes from the List of Plan Characteristics Codes printed in the instructions):
- (check this box if the plan provides welfare benefits and enter below the applicable welfare feature codes from the List of Plan Characteristics Codes printed in the instructions):

9a	9a Plan funding arrangement (check all that apply)				Plan	fit arrangement (check all that apply)		
	(1) X Insurance		Insurance	(1		X	Insurance	
	(2)		Code section 412(i) insurance contracts		(2)		Code section 412(i) insurance contracts	
	(3)		Trust		(3)		Trust	
	(4)		General assets of the sponsor	•	(4)		General assets of the sponsor	

10	Schedules attached (Check all	applicable boxes and, where indicated,	enter the number	r attached. See	instru	ctions.)
a	Pension Benefit Schedules		b Financial So			
	.1)	R (Retirement Plan Information)	1)		Н	(Financial Information)
	2)	T (Qualified Pension Plan Coverage Information)	2)		1	(Financial InformationSmall Plan)
	If a Schedule T is not atta	ached	3) 💢	003	A	(Insurance Information)
	because the plan is relyin coverage testing informati a prior year, enter the yea	ion for	4)		С	(Service Provider Information)
	, , , , , , , , , , , , , , , , , , , ,	·	5)		D	(DFE/Participating Plan Information)
	3)	B (Actuarial Information)				·
	4)	E (ESOP Annual Information)	6)		G	(Financial Transaction Schedules)
		E (ESOP Annual Information)	7)		P	(Trust Fiduciary Information)
	5)	SSA (Separated Vested Participant Information)		,		, , , , , , , , , , , , , , , , , , ,



SCHEDULE A (Form 5500)

Department of the Treasury Internal Revenue Service

Department of Labor
Pension and Welfare Benefits
Administration

Pension Benefit Guaranty Corporation

For calendar plan year 2002 or fiscal plan year beginning

Insurance Information

This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974.

File as an attachment to Form 5500.

▶ Insurance companies are required to provide this information pursuant to ERISA section 103(a)(2).

2002

09 3

30

2003

A Name of plan

INEEL LIFE INSURANCE PLAN

B Three-digit plan number

503

Official Use Only

OMB No. 1210-0110

This Form is Open to

Public Inspection.

C Plan sponsor's name as shown on line 2a of Form 5500

D

and ending

Employer Identification Number

BECHTEL BWXT IDAHO, LLC

94 3323797

Part I Information Concerning Insurance Contract Coverage, Fees, and Commissions

Provide information for each contract on a separate Schedule A. Individual contracts grouped as a unit in Parts II and III can be reported on a single Schedule A.

- 1 Coverage:
- (a) Name of insurance carrier

PRUDENTIAL FINANCIAL

- (b) EIN 22 1211670
- (c) NAIC code

68241

(d) Contract or identification number

24927-1

(e) Approximate number of persons covered at end of policy or contract year

3223

Policy or contract year

(f) From

71 01

01 2002

n) To

2

2002

Insurance fees and commissions paid to agents, brokers and other persons. Enter the total fees and total commissions below and list agents, brokers and other persons individually in descending order of the amount paid in the items on the following page(s) in Part I.

Totals

Total amount of commissions paid

Total fees paid / amount

U

2

For Paperwork Reduction Act Notice and OMB Control Numbers, see the instructions for Form 5500. Cat. No. 135051 Schedule A (Form 5500) 2002



v5.0

- (a) Name and address of the agents, brokers or other persons to whom commissions or fees were paid
- (b) Amount of commissions paid

(c) Fees paid / Amount

(e) Organization code

- (d) Fees paid / Purpose
- (a) Name and address of the agents, brokers or other persons to whom commissions or fees were paid
- (b) Amount of commissions paid

(c) Fees paid / Amount

(e) Organization code

(d) Fees paid / Purpose

- (a) Name and address of the agents, brokers or other persons to whom commissions or fees were paid
- (b) Amount of commissions paid

(c) Fees paid / Amount

(e) Organization code

(d) Fees paid / Purpose



Schedule	Α	(Form	5500)	2002
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Official Use Only

Part		1
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Investment and Annuity Contract Information

Where individual contracts are provided, the entire group of such individual contracts with each carrier may be treated as a unit for purposes of this report.

- 3 Current value of plan's interest under this contract in the general account at year end
- 4 Current value of plan's interest under this contract in separate accounts at year end
- 5 Contracts With Allocated Funds
- a State the basis of premium rates
- b Premiums paid to carrier
- c Premiums due but unpaid at the end of the year
- e Type of contract
- individual policies
- (2)

group deferred annuity

(3) other (specify below)

(1)

f If contract purchased, in whole or in part, to distribute benefits from a terminating plan check here

Schedule	Α	(Form	5500)	2002

Page 4

(1)	deposit administration	(2)	immediate participation guarantee	(3)	guarar	nteed investment
(4)	other (specify below)		•			
Balar	nce at the end of the previous ve				* · · · · · · · · · · · · · · · · · · ·	
	ions: Contributions deposited during th	ne year				
(2)	Dividends and credits					
(3)	Interest credited during the year					
4)	Transferred from separate accou	nt	·•			
(5)	Other (specify below)		••			
(6)	Total additions					
,			,			
		and c(6))				
	ictions: Disbursed from fund to pay bene	efits or				
	purchase annuities during year .		•••			
(2)	Administration charge made by	carrier				
(3)	Transferred to separate account		•••			
(4)	Other (specify below)	•••••				
		No.				
(5)	Total deductions	•••••••				
			9(5) from d)			



Part III

Welfare Benefit Contract Information

If more than one contract covers the same group of employees of the same employer(s) or members of the same employee organization(s), the information may be combined for reporting purposes if such contracts are experience-rated as a unit. Where individual contracts are provided, the entire group of such individual contracts with each carrier may be treated as a unit for purposes of this report.

7 Benefit and contract type (check all applicable boxes)

(a)	Health (other than dental or vision)	(b)	Dental	(c)	Vision	(d)	X	Life Insurance
(e)	Temporary disability (accident and sickness)	(f)	Long-term disability	(g)	Supplemental unemployment	(h)		Prescription drug
(1)	Stop loss (large deductible)	(I)	HMO contract	(k)	PPO contract	(1)		Indemnity contract
(m)	Other (specify below)			•				

8	Expe	rience	-rated	contracts

^	Dramiuma	

/1)	Amount received	

- (2) Increase (decrease) in amount due but unpaid......
- (3) Increase (decrease) in unearned premium reserve
- (4) Earned ((1) + (2) (3)).....

b Benefit charges:

- (1) Claims paid
- (2) Increase (decrease) in claim reserves
- (3) Incurred claims (add (1) and (2))
- (4) Claims charged

C	Ren	nainder of premium:	
	(1)	Retention charges (on an accrual basis)	
		(A) Commissions	
		(B) Administrative service or other fees	
		(C) Other specific acquisition costs	
		(D) Other expenses	
		(E) Taxes	
		(F) Charges for risks or other contingencies	
		(G) Other retention charges	
		(H) Total retention	
	(2)	Dividends or retroactive rate refunds.	
		(These amounts were 1) paid in cash, or 2) credited.)	
d	Stat	us of policyholder reserves at end of year:	·
u		Amount held to provide benefits after retirement	
	(2)	Claim reserves	
	(-/	Ciain 16561765	
	(3)	Other reserves	
	(0)	Cura 10301703	•
е		dends or retroactive rate refunds due.	
	(Do	not include amount entered in c(2).)	
9	Non	experience-rated contracts:	
а	Tota	premiums or subscription charges paid to carrier	1019403
þ	If the	e carrier, service, or other organization incurred any specific costs	
4-	othe	onnection with the acquisition or retention of the contract or policy, r than reported in Part I, item 2 above, report amount	
		cify nature of costs below	
		The same of the sa	



SCHEDULE A (Form 5500)

Department of the Treasury Internal Revenue Service

Department of Labor Pension and Welfare Benefits Administration

Pension Benefit Guaranty Corporation

For calendar plan year 2002 or fiscal plan year beginning

Insurance Information

This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974.

File as an attachment to Form 5500.

Insurance companies are required to provide this information pursuant to ERISA section 103(a)(2). Official Use Only

OMB No. 1210-0110

2002

This Form is Open to Public Inspection.

10 01 2002 and ending 09 30 2003

A Name of plan

INEEL LIFE INSURANCE PLAN

B Three-digit plan number

503

C Plan sponsor's name as shown on line 2a of Form 5500

BECHTEL BWXT IDAHO, LLC

D Employer Identification Number

94 3323797

Part I Information Concerning Insurance Contract Coverage, Fees, and Commissions

Provide information for each contract on a separate Schedule A. Individual contracts grouped as a unit in Parts II and III can be reported on a single Schedule A.

- 1 Coverage:
- (a) Name of insurance carrier

PRUDENTIAL FINANCIAL

- (b) EIN 22 /2//670
- (c) NAIC code
- 68241

- (d) Contract or identification number
- 23750-1
- (e) Approximate number of persons covered at end of policy or contract year

5670

Policy or contract year

(f) From

1 0

2002

\ To /

.

200=

Insurance fees and commissions paid to agents, brokers and other persons. Enter the total fees and total commissions below and list agents, brokers and other persons individually in descending order of the amount paid in the items on the following page(s) in Part I.

Totals

Total amount of commissions paid

Total fees paid / amount

[]

For Paperwork Reduction Act Notice and OMB Control Numbers, see the instructions for Form 5500. Cat. No. 13505I Schedule A (Form 5500) 2002



v5.0

- (a) Name and address of the agents, brokers or other persons to whom commissions or fees were paid
- (b) Amount of commissions paid

(c) Fees paid / Amount

(e) Organization code

- (d) Fees paid / Purpose
- (a) Name and address of the agents, brokers or other persons to whom commissions or fees were paid
- (b) Amount of commissions paid

(c) Fees paid / Amount

(e) Organization code

- (d) Fees paid / Purpose
- (a) Name and address of the agents, brokers or other persons to whom commissions or fees were paid
- (b) Amount of commissions paid

(c) Fees paid / Amount

(e) Organization code

(d) Fees paid / Purpose

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Schedule	Α	(Form	5500)	2002

Official Use Only

Part	ł

Investment and Annuity Contract Information

Where individual contracts are provided, the entire group of such individual contracts with each carrier may be treated as a unit for purposes of this report.

- 3 Current value of plan's interest under this contract in the general account at year end
- 4 Current value of plan's interest under this contract in separate accounts at year end
- 5 Contracts With Allocated Funds
- a State the basis of premium rates
- b Premiums paid to carrier
- c Premiums due but unpaid at the end of the year
- e Type of contract
- (1) individual policies
- (2)

group deferred annuity

- (3) other (specify below)
- f If contract purchased, in whole or in part, to distribute benefits from a terminating plan check here

	_			
Schedule	Α	(Form	5500)	2002

(1)	deposit administration	(2)	immediate participation guarantee	(3)	guaranteed investment
(4)	other (specify below)				
	•				
Bala	ance at the end of the previous year	***************************************			
Add	itions:				
(1)	Contributions deposited during the	year	•		
(2)	Dividends and credits	•••••			
(3)	Interest credited during the year				
(4)	Transferred from separate account				
(5)	Other (specify below)	••••••••••			
(6)	Total additions	*************************			
			,		
Total	of balance and additions (add b ar	nd c (6))			
Ded	uctions: Disbursed from fund to pay benefits				
1.7	purchase annuities during year				
(2)	Administration charge made by can	ier			
(3)	Transferred to separate account	•••••			
(4)					
(7)	Other (specify below)	****************	·		
(5)	Total deductions				



Part III

Welfare Benefit Contract Information

If more than one contract covers the same group of employees of the same employer(s) or members of the same employee organization(s), the information may be combined for reporting purposes if such contracts are experience-rated as a unit. Where individual contracts are provided, the entire group of such individual contracts with each carrier may be treated as a unit for purposes of this report.

7 Benefit and contract type (check all applicable boxes)

(a)	Health (other than dental or vision)	(b)	Dental	(c)	Vision	(d)	X	Life Insurance
(e)	Temporary disability (accident and sickness)	(f)	Long-term disability	(g)	Supplemental unemployment	(h)		Prescription drug
(1)	Stop loss (large deductible)	()	HMO contract	(k)	PPO contract	(1)		Indemnity contract
(m)	Other (specify below)							

	Ехр	erience-rated contracts		
3	Prer <i>(1)</i>	miums: Amount received	1680999	
	(2)	Increase (decrease) in amount due but unpaid	-171476	
	(3)	Increase (decrease) in unearned premium reserve		
	(4)	Earned ((1) + (2) - (3))		1509523
•	Ben <i>(1)</i>	efit charges: Claims paid	1579085	
	(2)	Increase (decrease) in claim reserves	57837	
	(3)	Incurred claims (add (1) and (2))	 •••• • • • • • • • • • • • • • • • • •	1636922
	(4)	Claims charged	•••••	1636922



Schedule	Α	(Form	5500)	2002
	$\boldsymbol{\Gamma}$	(i otti	22001	4002

C	Ren	nainder of premium:		Official Ose Office
	(1)	Retention charges (on an accrual basis)		
		(A) Commissions		
		(B) Administrative service or other fees		
		(C) Other specific acquisition costs		
		(D) Other expenses	-37015	
		(E) Taxes	50481	
		(F) Charges for risks or other contingencies	25959	•
		(G) Other retention charges	•	
		(H) Total retention		39 425
	(2)	Dividends or retroactive rate refunds.		0 / 10 3
	•	(These amounts were 1) paid in cash, or 2) credited.)		en e
d	Statu	is of policyholder reserves at end of year:		
	(1)	Amount held to provide benefits after retirement		
	(2)	Claim reserves		
	(3)	Other reserves		
			,	
е	Divid (Do r	ends or retroactive rate refunds due. not include amount entered in c <i>(2)</i> .)		
į	None	xperience-rated contracts:		
a .	Total	premiums or subscription charges paid to carrier		
	II COI	carrier, service, or other organization incurred any specific costs inection with the acquisition or retention of the contract or policy, than reported in Part I, item 2 above, report amount	-	
\$	Speci	fy nature of costs below		

SCHEDULE A (Form 5500)

Department of the Treasury Internal Revenue Service

Department of Labor Pension and Welfare Benefits Administration

Pension Benefit Guaranty Corporation

For calendar plan year 2002 or fiscal plan year beginning

Insurance Information

This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974.

▶ File as an attachment to Form 5500.

Insurance companies are required to provide this information pursuant to ERISA section 103(a)(2).

Official Use Only

OMB No. 1210-0110

This Form is Open to Public Inspection.

2002

and ending

09

30

2003

A Name of plan

INEEL LIFE INSURANCE PLAN

Three-digit plan number

5o3

Plan sponsor's name as shown on line 2a of Form 5500

BECHTEL BWXT IDAHO, LLC

Employer Identification Number

94 3323797

Information Concerning Insurance Contract Coverage, Fees, and Commissions Provide information for each contract on a separate Schedule A. Individual contracts grouped as a unit in Parts II and III can be reported on a single Schedule A.

1 Coverage:

Part I

Name of insurance carrier

PRUDENTIAL FINANCIAL

22 1211670 EIN (b)

(c) NAIC code

68241

Contract or identification number

23750-3

Approximate number of persons covered at end of policy or contract year

8898

Policy or contract year

(f) From

01 01 2002

.31

2002

Insurance fees and commissions paid to agents, brokers and other persons. Enter the total fees and total commissions below and list agents, brokers and other persons individually in descending order of the amount paid in the items on the following page(s) in Part I.

Totals

Total amount of commissions paid

Total fees paid / amount

For Paperwork Reduction Act Notice and OMB Control Numbers, see the instructions for Form 5500. Cat. No. 135051 Schedule A (Form 5500) 2002



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- (a) Name and address of the agents, brokers or other persons to whom commissions or fees were paid
- (b) Amount of commissions paid

(c) Fees paid / Amount

(e) Organization code

- (d) Fees paid / Purpose
- (a) Name and address of the agents, brokers or other persons to whom commissions or fees were paid
- (b) Amount of commissions paid

(c) Fees paid / Amount

(e) Organization code

- (d) Fees paid / Purpose
- (a) Name and address of the agents, brokers or other persons to whom commissions or fees were paid
- (b) Amount of commissions paid

(c) Fees paid / Amount

(e) Organization code

(d) Fees paid / Purpose



Schedule	Α	(Form	5500	2002
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Official Use Only

Part II

Investment and Annuity Contract Information

Where individual contracts are provided, the entire group of such individual contracts with each carrier may be treated as a unit for purposes of this report.

- 3 Current value of plan's interest under this contract in the general account at year end
- 4 Current value of plan's interest under this contract in separate accounts at year end
- 5 Contracts With Allocated Funds
- a State the basis of premium rates
- b Premiums paid to carrier
- c Premiums due but unpaid at the end of the year

e Type of contract

(1)

individual policies

(2)

group deferred annuity

(3) other (specify below)

f If contract purchased, in whole or in part, to distribute benefits from a terminating plan check here

Schedule	Α	(Form	5500	2002
		() OIIII	0000	

(1)	deposit administration	(2)	immediate participation guarantee	(3)	guaranteed investmen
(4)	other (specify below)				
	•				
			1		
Baland	ce at the end of the previous yea	r			
Additio	ons:				
(1) C	Contributions deposited during the	e year	•		
<i>(2)</i> D	Dividends and credits				
<i>(3</i>) lı	nterest credited during the year .				
	•				
<i>(4)</i> T	ransferred from separate accoun	t			
<i>(5)</i> C	Other (specify below)				
<i>(6)</i> T	otal additions	••••••			
				•	
Total o		and c (6))			
	aions: Disbursed from fund to pay benef	its or			
p	urchase annuities during year	•••••			
(2) A	dministration charge made by ca	arrier			
<i>(3)</i> T	ransferred to separate account				
(4)C	Other (specify below)	••••••			
					
/E\ -	Shal daduations				
<i>(5)</i> T	olai deductions	••••••			
	,				



Schedule	Α	(Form	5500	2002
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Official Use Only

Part III Welfare Benefit Contract Information

If more than one contract covers the same group of employees of the same employer(s) or members of the same employee organization(s), the information may be combined for reporting purposes if such contracts are experience-rated as a unit. Where individual contracts are provided, the entire group of such individual contracts with each carrier may be treated as a unit for purposes of this report.

7 Benefit and contract type (check all applicable boxes)

(a)	Health (other than dental or vision)	(b)		Dental	(c)	Vision	(d)	X	Life Insurance
(e)	Temporary disability (accident and sickness)	(f)	:	Long-term disability	(g)	Supplemental unemployment	(h)		Prescription drug
(1)	Stop loss (large deductible)	()		HMO contract	(k)	PPO contract	(i)		Indemnity contract
(m)	Other (specify below)				ė				

8 Experience-rated contract	cts
-----------------------------	-----

а		niums: Amount received
	(2)	Increase (decrease) in amount due but unpaid
	(3)	Increase (decrease) in unearned premium reserve

(4)	Earned ((1) +	(2) -	(3))
-----	---------------	-------	------

D	Revetit	charges:
---	---------	----------

(1)	Claims paid	
-----	-------------	--

(2) Increase (decrease)) in	claim	reserves	
-------------------------	------	-------	----------	--

(3)	Incurred claims (add (1) and (2))	*******************************

,	c Her	nainder of premium:		
	(1)	Retention charges (on an accrual basis)		
		(A) Commissions		
		(B) Administrative service or other fees		
		(C) Other specific acquisition costs		
		(D) Other expenses		
		(E) Taxes		
		(F) Charges for risks or other contingencies		
		(G) Other retention charges		
		(H) Total retention		
	(2)	Dividends or retroactive rate refunds.		
		(These amounts were 1) paid in cash, or 2)	anadita d	
		paid in oddi, or 2)	credited.)	
d	Stat	us of policyholder reserves at end of year:		
	(1)	Amount held to provide benefits after retirement	••••••	
	(2)	Claim reserves	••••••	
	(3)	Other reserves		
е	Divid	lends or retroactive rate refunds due.		
	(טט	not include amount entered in c(2).)	100011100110111011111111111111111111111	
9	None	experience-rated contracts:		
a	Total	premiums or subscription charges paid to carrier		1596029
		• •	•••••••••••••••••••••••••••••••••••••••	15/602/
b	If the	carrier, service, or other organization incurred any specific cost	ts	
	other	nnection with the acquisition or retention of the contract or polic than reported in Part I, item 2 above, report amount	y,	
	Spec	ify nature of costs below		

Form 5500

Department of the Treasury
Internal Revenue Service
Department of Labor
Pension and Welfare Benefits
Administration
Pension Benefit
Guaranty Corporation

Annual Return/Report of Employee Benefit Plan

This form is required to be filed under sections 104 and 4065 of the Employee Retirement income Security Act of 1974 (ERISA) and sections 6047(e),

Official Use Only
OMB Nos. 1210-0110 / 1210-0089

2002

This Form is Open to Public Inspection.

6057(b), and 6058(a) of the Internal Revenue Code (the Code).

▶ Complete all entries in accordance with the instructions to the Form 5500.

Part I Annual Repo	rt Identii	ication Ir	nformation	n					
For the calendar plan ye or fiscal plan year begin	ar 2002 ning	10	01	2002	and	ending	09	30	2003
A This return/report is for:	(1)	a multierr	nployer plan;		(3)	a multipl	e-employer j	olan; or	
	(2)		employer plar e-employer pl	n (other than lan);	(4)	a DFE (s	specify)	······································	
B This return/report is:	(1)	the first re	eturn/report f	filed for the plan;	(3)	the final	return/repor	t filed for th	e plan;
	(2)	an amend	ded return/re	port;	(4)	•	olan year ret	•	
C If the plan is a collectively	-bargained	plan, check	here				n 12 months		>
Part II Basic Plan In 1a Name of plan TNEEL				sted informatio		5/	TY	PLA	† N
1b Three-digit plan number	er (PN) ▶	508	3	1c Eff	ective date	of plan	08	01	1992
Caution: A penalty for the land Under penalties of perjury schedules, statements and at knowledge and belief, it is true signature of plan administrations. SIGN HERE Type or print name of inditional CANDAC Signature of employer/plants	and other p tachments, e, correct a ator correct a vidual signing	enalties set as well as the complete as a splan adm	forth in the inthe electronic e. **Control of the control of the	nrn/report will be a nstructions, I declar c version of this re	assessed ure that I ha	unless reas	d this return	report incl	udina accompanyina
		_	Wilker	in)		_	04		2224
Type or print name of indi						Date	04	a o	2004
b CANDAC		_		_				. /	
For Paperwork Reduction A	ct Notice a	nd OMB Co	ntrol Numbe	ers, see the instru	ictions for	Form 5500	. Cat. No	o. 13500F	Form 5500 (2002)

v5.0

Plan sponsor's name and address (employer, if for single-employer plan) (Address should include room or suite no.) 2a

BECHTEL BWXT IDAHO, 1)

C/O CANDACE F WILKINSON 2)

PO BOX 1625 1955 FREEMONT AVE

IDAHO FALLS

2b Employer Identification Number (EIN)

ID 83415-3200

94 3323797

2c Sponsor's telephone number

208 526 0066

2d Business code (see instructions)

541990

3a Plan administrator's name and address (If same as plan sponsor, enter "Same")

SAME 1)

c/o2)

3)

6)

7)

8)

9)

4)

5)

7)

6)

3b Administrator's EIN

3c Administrator's telephone number

If the name and/or EIN of the plan sponsor has changed since the last return/report filed for this plan, enter the name, EIN and the plan number from the last return/report below:

Sponsor's name

EIN

c PN



Form 5500 (2002
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Official Use Only

4969

4969

5	Preparer	information	(optional)
---	----------	-------------	------------

Name (including firm name, if applicable) and address

1)

2)

3)

4)

5)

6)

b EIN

c Telephone number

6	Total number of participants at the beginn	ing of the plan year	5053
	en e		

Number of participants as of the end of the plan year (welfare plans complete only lines 7a, 7b, 7c, and 7d)

a Active participants

b Retired or separated participants receiving benefits.....

c Other retired or separated participants entitled to future benefits.....

1 Total. Add lines 7d and 7e

Deceased participants whose beneficiaries are receiving or are entitled to receive benefits......

g Number of participants with account balances as of the end of the plan year (only defined

contribution plans complete this item)

h Number of participants that terminated employment during the plan year with accrued benefits that were less than 100% vested.....

I If any participant(s) separated from service with a deferred vested benefit, enter the number of separated participants required to be reported on a Schedule SSA (Form 5500)



Form	5500	(2002)

3	Benefits	provided	under	the	plan	(complete	8a	and	8b,	as	applicable
---	----------	----------	-------	-----	------	-----------	----	-----	-----	----	------------

- Pension benefits (check this box if the plan provides pension benefits and enter below the applicable pension feature codes from the List of Plan Characteristics Codes printed in the instructions):
- Welfare benefits (check this box if the plan provides welfare benefits and enter below the applicable welfare feature codes from the List of Plan Characteristics Codes printed in the instructions):

4F

- 9a Plan funding arrangement (check all that apply) 9b Plan benefit arrangement (check all that apply) Insurance Insurance Code section 412(i) insurance contracts (2)Code section 412(i) insurance contracts (3) Trust (3) Trust (4) General assets of the sponsor (4) General assets of the sponsor

SSA (Separated Vested

Participant Information)

Schedules attached (Check all applicable boxes and, where indicated, enter the number attached. See instructions.) a Pension Benefit Schedules b Financial Schedules 1) R (Retirement Plan Information) 1) (Financial Information) 2) (Qualified Pension Plan 2) (Financial Information--Small Plan) Coverage Information) 001 3) (Insurance Information) If a Schedule T is not attached because the plan is relying on 4) coverage testing information for (Service Provider Information) a prior year, enter the year 5) (DFE/Participating Plan Information) 3) (Actuarial Information) 6) (Financial Transaction Schedules) 4) (ESOP Annual Information) 7) (Trust Fiduciary Information) 5)



SCHEDULE A (Form 5500)

Department of the Treasury Internal Revenue Service

Department of Labor Pension and Welfare Benefits Administration

Pension Benefit Guaranty Corporation

For calendar plan year 2002 or fiscal plan year beginning

Insurance Information

This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974.

▶ File as an attachment to Form 5500.

Insurance companies are required to provide this information pursuant to ERISA section 103(a)(2). Official Use Only

OMB No. 1210-0110

2002

This Form is Open to Public Inspection.

10 01 2002

and ending

.

30

2003

A Name of plan

INEEL SHORT TERM DISABILITY PLAN

B Three-digit plan number

508

C Plan sponsor's name as shown on line 2a of Form 5500

BECHTEL BWXT IDAHO, LLC

D Employer Identification Number

94 3323797

Part I Information Concerning Insurance Contract Coverage, Fees, and Commissions

Provide information for each contract on a separate Schedule A. Individual contracts grouped as a unit in Parts II and III can be reported on a single Schedule A.

- 1 Coverage:
- (a) Name of insurance carrier

CIGNA LIFE INSURANCE COMPANY OF NORTH AMERICA

(b) EIN

23 1503749

(c) NAIC code

65498

(d) Contract or identification number

LK 008044

(e) Approximate number of persons covered at end of policy or contract year

5189

Policy or contract year

(f) From

01 01 2002

a) To

2 31

2002

Insurance fees and commissions paid to agents, brokers and other persons. Enter the total fees and total commissions below and list agents, brokers and other persons individually in descending order of the amount paid in the items on the following page(s) in Part I.

Totals

Total amount of commissions paid

Total fees paid / amount

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- (a) Name and address of the agents, brokers or other persons to whom commissions or fees were paid
- (b) Amount of commissions paid

(c) Fees paid / Amount

(e) Organization code

(d) Fees paid / Purpose

- (a) Name and address of the agents, brokers or other persons to whom commissions or fees were paid
- (b) Amount of commissions paid

(c) Fees paid / Amount

(e) Organization code

- (d) Fees paid / Purpose
- (a) Name and address of the agents, brokers or other persons to whom commissions or fees were paid
- (b) Amount of commissions paid

(c) Fees paid / Amount

(e) Organization code

(d) Fees paid / Purpose



Schedule	Α	(Form	5500)	2002
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Investment and Annuity Contract Information

Where individual contracts are provided, the entire group of such individual contracts with each carrier may be treated as a unit for purposes of this report.

- 3 Current value of plan's interest under this contract in the general account at year end
- 4 Current value of plan's interest under this contract in separate accounts at year end
- 5 Contracts With Allocated Funds
- a State the basis of premium rates
- b Premiums paid to carrier
- c Premiums due but unpaid at the end of the year
- e Type of contract
- individual policies
- (2)

group deferred annuity

(3) other (specify below)

(1)

f If contract purchased, in whole or in part, to distribute benefits from a terminating plan check here

6

Contracts Type of co		o not includ	le portions of these contracts maintained in	separate acc	ounts)
(1)	deposit administration	(2)	immediate participation guarantee	(3)	guaranteed investment
(4)	other (specify below)				
Balance	at the end of the previous y	əar	. '		
Additions	: tributions deposited during	the year	, 		
<i>(2)</i> Divi	dends and credits				
(3) Inte	rest credited during the yea	r			
(4) Trai	nsferred from separate acco	unt			
(5) Oth	ner (specify below)		· · · · · ·		
•					
(O) T-4					
<i>(6)</i> Tot	al additions	*************	`		
i Total of Deducti		b and c (6,))		
	sbursed from fund to pay be rchase annuities during yea				
(2) Ac	lministration charge made b	y carrier			
<i>(3)</i> Tra	ansferred to separate accou	nt			
(4) O	ther (specify below)				
•					
/E) T	ntal deductions				
<i>(5)</i> To	DIGI UGUUUIIUII				1
f Baland	ce at the end of the current	year (subtr	act e (5) from d)		*



Part III

Welfare Benefit Contract Information

If more than one contract covers the same group of employees of the same employer(s) or members of the same employee organization(s), the information may be combined for reporting purposes if such contracts are experience-rated as a unit. Where individual contracts are provided, the entire group of such individual contracts with each carrier may be treated as a unit for purposes of this report.

7 Benefit and contract type (check all applicable boxes)

(a)		Health (other than dental or vision)	(b)	Dental	(c)	Vision	(d)	Life Insurance
(e)	X	Temporary disability (accident and sickness)	(f)	Long-term disability	(g)	Supplemental unemployment	(h)	Prescription drug
(i)		Stop loss (large deductible)	(1)	HMO contract	(k)	PPO contract	(l)	Indemnity contract
(m)		Other (specify below)			,			

8 Experience-rated	contracts
--------------------	-----------

9	Premiume	

(1)	Amount	received	

(2)	Increase (decrease)
	in amount due but unpaid

(3)	Increase (decrease) in		
	unearned premium reserve		

(4)	Earned ((1) +	(2) - (3))
-----	---------------	------------

b B	enefit	cha	rges:
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(1) Claims naid

(2) Increase (decrease) in claim reserves

(3) Incurred claims (add (1) and (2))

(4) Claims charged

C	Rem	ainder of premium:	
	(1)	Retention charges (on an accrual basis)	
		(A) Commissions	
		(B) Administrative service or other fees	
		(C) Other specific acquisition costs	
		(D) Other expenses	
		(E) Taxes	
		(F) Charges for risks or other contingencies	
		(G) Other retention charges	
		(LI) Takel veks alice	
	(01	(H) Total retention	••
	(2)	Dividends or retroactive rate refunds.	
		(These amounts were 1) paid in cash, or 2) credited.)	
d	Stat	us of policyholder reserves at end of year:	
_		Amount held to provide benefits after retirement	···
			•
	(2)	Claim reserves	
	(2)	Claim reserves	•••
	(3)	Other reserves	
е	Divi	dends or retroactive rate refunds due.	
	(Do	not include amount entered in c(2).)	
ì	Non	experience-rated contracts:	
а	Tota	I premiums or subscription charges paid to carrier	2419467
			, , , ,
b		e carrier, service, or other organization incurred any specific costs	
		onnection with the acquisition or retention of the contract or policy,	and the second s
		r than reported in Part I, item 2 above, report amount cify nature of costs below	···
	Ope	on thatare of coole below	